

**State of California
Business, Consumer Services and Housing Agency**

MEDICAL BOARD OF CALIFORNIA

July 27-28, 2017

Board Meeting

Legislative Packet



MEDICAL BOARD OF CALIFORNIA - 2017 TRACKER LIST
July 18, 2017

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 40	Santiago	CURES Database: Health Information Technology System	Sen. Judiciary	Support in Concept	7/10/17
AB 148	Mathis	California Physician Corps: Practice Setting	Sen. Approps.	Neutral	7/17/17
AB 182	Waldron	Heroin and Opioid Public Education (HOPE) Act	Sen. Approps.	Support	5/26/17
AB 443	Salas	Optometry: Scope of Practice	Sen. Approps.	Reco: Oppose Unless Amended	7/5/17
AB 505	Caballero	Physicians and Surgeons: Probation	Sen. B&P	Oppose	3/27/17
AB 706	Patterson	Medical Board of California: Licenses	2-Year Bill	Not Moving Forward	
AB 715	Wood	Workgroup Review of Opioid Pain Reliever Use and Abuse	Sen. Approps.	Neutral	6/8/17
AB 845	Wood	Cannabidiol	Sen. Approps.	Neutral	7/11/17
AB 1048	Arambula	Health Facilities: Pain Management and Schedule II Drug Prescriptions	Sen. Approps.	Support	7/3/17
AB 1204	Mayes	Public Health: Emergency Prescriptions	2-Year Bill	Neutral if Amended	3/28/17
AB 1340	Maienschein	Continuing Medical Education: Mental and Physical Health Care Integration	Sen. 3 rd Reading	Neutral	6/14/17
AB 1368	Calderon	Health Professionals: Authorization Forms	Sen. Approps.	Neutral	6/29/17
AB 1512	McCarty	Opioid Addiction Prevention and Rehabilitation Act	2-Year Bill	Support if Amended	5/9/17
AB 1560	Friedman	Nurse Practitioners: Certified Nurse-Midwives: Physician Assistants: Supervision	Sen. 3 rd Reading	Oppose Unless Amended	7/3/17

Pink – Sponsored Bill, Green – For Discussion, Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA - 2017 TRACKER LIST

July 18, 2017

AB 1612	Burke	Certified Nurse-Midwives: Physician Supervision	2-Year Bill	Oppose Unless Amended	4/18/17
AB 1650	Maienschein	Emergency Medical Services: Community Paramedicine	2-Year Bill	Oppose	4/20/17
SB 241	Monning	Medical Records: Access	Assembly	Support	
SB 419	Portantino	Medical Practice: Pain Management	2-Year Bill		4/17/17
SB 457	Bates	Out-of-Hospital Childbirths	2-Year Bill		4/17/17
SB 512	Hernandez	Health Care Practitioners: Stem Cell Therapy	Asm. Approps.	Reco: Neutral	7/17/17
SB 554	Stone	Nurse Practitioners: Physician Assistants: Buprenorphine	Asm. 3 rd Reading	Support	6/14/17
SB 641	Lara	CURES: Privacy	Asm. Public Safety	Neutral	4/20/17
SB 715	Newman	DCA: Regulatory Boards: Removal of Board Members	Assembly	FYI Only	4/25/17
SB 746	Portantino	Pupil Health: Physical Examinations	2-Year Bill	Oppose Unless Amended	
SB 790	McGuire	Health Care Providers: Gifts and Benefits	Asm. 3 rd Reading	Support	7/6/17
SB 796	Hill	Uniform Standards: Naturopathic Doctors Act: Respiratory Care Practice Act	Asm. Approps.	Reco: Support the provision related to Uniform Standards	7/17/17
SB 798	Hill	Medical Board of California: Sunset Bill	Asm. B&P	Support if Amended	7/6/17

Pink – Sponsored Bill, Green – For Discussion, Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 40
Author: Santiago
Bill Date: July 10, 2017, Amended
Subject: CURES Database: Health Information Technology System
Sponsor: California Chapter, American College of Emergency Physicians
Position: Support in Concept

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow authorized health information technology systems to integrate with and automatically query the Controlled substances Utilization Review and Evaluation System (CURES) on behalf of an authorized health care practitioner.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General's Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

ANALYSIS

This bill would allow an authorized health care practitioner or a pharmacist to access the CURES database through an authorized health information technology system.

This bill would allow an entity that operates a health information technology system to establish an integration with, and submit queries to, the CURES database on either a user-initiated basis or an automated basis, if the entity can certify all of the following:

- The health information technology system is authorized to query the CURES database on behalf of an authorized health care practitioner or pharmacist on either a user-initiated basis, an automated basis, or both, for purposes of delivering patient data from the CURES database to assist an authorized health care practitioner or pharmacist with evaluating the need for medical or pharmaceutical treatment or providing medical or pharmaceutical treatment to a patient for whom a health care practitioner or pharmacist is providing, or has provided, care.
- The health information technology system will authenticate the identity of any authorized health care practitioner or pharmacist initiating queries to the CURES database on either a user-initiated basis or an automated basis, and, at the time of the query, the health information technology system will submit the following data regarding the query to CURES:
 - The date of the query.
 - The time of the query.
 - The first and last name of the patient queried.
 - The date of birth of the patient queried.
 - The identification of the CURES user for whom the system is making the query.
- The health information technology system will meet applicable patient privacy and information security requirements of state and federal law.

The bill would define a “health information technology system” as an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for the communication, decision making, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

This bill would define “user-initiated basis” to mean that an authorized health care practitioner or pharmacist has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner or pharmacist.

This bill would define “automated basis” to mean using a predefined criteria established or approved by a health care practitioner or pharmacist to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

Previously this bill would have allowed DOJ to determine, in its discretion, whether to establish a direct system integration between one or more health information technology systems and the CURES database, or whether to develop a gateway system to which multiple health information technology systems can establish an integration to access the CURES database. This bill would now require DOJ to develop a programming interface

or other method of system integration to allow all health information technology systems that meet the specified requirements to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

This bill would specify that DOJ shall not access patient identifiable information in an entity's health information technology system. This bill would require an entity that operates a health information technology system to pay a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database. This bill would allow DOJ to prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information system fails to meet the requirements in this bill, or the entity operating the health information technology system does not fulfill its obligation to pay fees.

This bill contains an urgency clause, so it would become effective immediately once signed into law.

According to the sponsor, allowing CURES to integrate with health information technologies will allow prescription information to be included in the same patient information that physicians receive, without requiring the physician to manually check the CURES database separately. This will help to reduce stress on California's overcrowded emergency departments, allow emergency physicians to more efficiently treat patients, and help to ensure that patients receive timely care.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent doctor shopping. The Board currently supports the concept of integrating existing health information technology systems with the CURES database, as this will allow CURES to be used more efficiently and effectively, as long as adequate protections are maintained. This efficiency will be important when the law becomes effective that requires all prescribers to consult the CURES database before initially prescribing a Schedule II, III or IV controlled substance. However, the Board believes it important that this integration isn't limited to a small number of health information technology systems, as the Board believes it is important that all physicians have access to the CURES integration and associated efficiency proposed by this bill.

This bill was amended to delete the provisions that would have given DOJ the discretion to decide which health information technology systems would have access to CURES integration, and now allows all health information technology systems that meet the specified requirements to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist. As such, Board staff recommends that the Board now support this bill.

FISCAL: None to the Board

SUPPORT: California Chapter, American College of Emergency Physicians (Sponsor); California Academy of Family Physicians; California Access Coalition; California Health+ Advocates; California Pharmacists Association; County Health Executives Association

of California; Health Officers Association of California; and
Medical Board of California (In Concept)

OPPOSITION: California Dental Association
California Medical Association

POSITION: Recommendation: Support

AMENDED IN SENATE JULY 10, 2017

AMENDED IN SENATE JULY 5, 2017

AMENDED IN ASSEMBLY MAY 26, 2017

AMENDED IN ASSEMBLY APRIL 19, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 40

Introduced by Assembly Member Santiago

December 5, 2016

An act to amend Section 11165.1 of the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 40, as amended, Santiago. CURES database: health information technology system.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance.

This bill would require the Department of Justice to make the electronic history of controlled substances dispensed to an individual under a health care practitioner's care, based on data contained in the CURES database, available to the ~~practitioner~~ *practitioner, or a*

pharmacist, as specified, through either an online Internet Web portal or an authorized health information technology system, as defined. The bill would authorize an entity that operates a health information technology system to establish an integration with and submit queries to the CURES database if the entity can certify, among other requirements, that the data received from the CURES database will not be used for any purpose other than delivering the data to an authorized health care practitioner or performing data processing activities necessary to enable delivery, and that the system meets applicable patient privacy and information security requirements of state and federal law. The bill would also require an entity operating a health information technology system that is requesting to establish an integration with the CURES database to pay a reasonable system maintenance fee and be subject to enforcement mechanisms, as specified. fee. The bill would prohibit the department from accessing patient-identifiable information in an entity's health information technology system. The bill would authorize the department to prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information technology system or the entity operating the health information technology system does not comply with specified provision of the bill.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 11165.1 of the Health and Safety Code,
2 as amended by Section 2 of Chapter 708 of the Statutes of 2016,
3 is amended to read:
4 11165.1. (a) (1) (A) (i) A health care practitioner authorized
5 to prescribe, order, administer, furnish, or dispense Schedule II,
6 Schedule III, or Schedule IV controlled substances pursuant to
7 Section 11150 shall, before July 1, 2016, or upon receipt of a
8 federal Drug Enforcement Administration (DEA) registration,
9 whichever occurs later, submit an application developed by the
10 department to obtain approval to access information regarding the
11 controlled substance history of a patient through an online Internet
12 Web portal that is maintained by the department, or through an

1 authorized health information technology system. Upon approval,
2 the department shall release to that practitioner, through an online
3 Internet Web portal or an authorized health information technology
4 system, the electronic history of controlled substances dispensed
5 to an individual under his or her care based on data contained in
6 the CURES Prescription Drug Monitoring Program (PDMP).

7 (ii) A pharmacist shall, before July 1, 2016, or upon licensure,
8 whichever occurs later, submit an application developed by the
9 department to obtain approval to access information online
10 regarding the controlled substance history of a patient that is stored
11 on the Internet and maintained within the ~~department~~. *department,*
12 *or through an authorized health information technology system.*
13 Upon approval, the department shall release to that pharmacist the
14 electronic history of controlled substances dispensed to an
15 individual under his or her care based on data contained in the
16 CURES PDMP.

17 (B) An application may be denied, or a subscriber may be
18 suspended, for reasons which include, but are not limited to, the
19 following:

20 (i) Materially falsifying an application to access information
21 contained in the CURES database.

22 (ii) Failing to maintain effective controls for access to the patient
23 activity report.

24 (iii) Having his or her federal DEA registration suspended or
25 revoked.

26 (iv) Violating a law governing controlled substances or any
27 other law for which the possession or use of a controlled substance
28 is an element of the crime.

29 (v) Accessing information for a reason other than to diagnose
30 or treat his or her patients, or to document compliance with the
31 law.

32 (C) An authorized subscriber shall notify the department within
33 30 days of any changes to the subscriber account.

34 (D) An entity that operates a health information technology
35 system may establish an integration with and submit queries to the
36 CURES database on either a user-initiated basis or an automated
37 basis if the entity can certify all of the following:

38 (i) The health information technology system is authorized to
39 query the CURES database on behalf of an authorized health care
40 practitioner *or pharmacist* on either a user-initiated basis, an

1 automated basis, or both, for purposes of delivering patient data
2 from the CURES database to assist an authorized health care
3 practitioner *or pharmacist* to evaluate the need for medical or
4 pharmaceutical treatment or provide medical or pharmaceutical
5 treatment to a patient for whom a health care practitioner *or*
6 *pharmacist* is providing or has provided care.

7 ~~(ii) The entity will not use or disclose data received from the~~
8 ~~CURES database for any purpose other than delivering the data~~
9 ~~to an authorized health care practitioner or performing data~~
10 ~~processing activities that may be necessary to enable this delivery.~~

11 ~~(iii)~~
12 (ii) The health information technology system will authenticate
13 the identity of an authorized health care practitioner *or pharmacist*
14 initiating queries to the CURES database on either a user-initiated
15 basis or an automated basis and, at the time of the query to the
16 CURES database, the health information technology system
17 submits the following data regarding the query to CURES:

- 18 (I) The date of the query.
19 (II) The time of the query.
20 (III) The first and last name of the patient queried.
21 (IV) The date of birth of the patient queried.
22 (V) The identification of the CURES user for whom the system
23 is making the query.

24 ~~(iv)~~
25 (iii) The health information technology system meets applicable
26 patient privacy and information security requirements of state and
27 federal law.

28 ~~(E) The department may, in its discretion, determine whether~~
29 ~~to establish a direct system integration between one or more health~~
30 ~~information technology systems and the CURES database, or~~
31 ~~whether to develop a gateway system to which multiple health~~
32 ~~information technology systems can establish an integration for~~
33 ~~purposes of accessing the CURES database. The CURES database~~
34 ~~shall not permit access to patient-identifiable information in an~~
35 ~~entity's health information technology system.~~

36 (E) *The department shall develop a programming interface or*
37 *other method of system integration to allow health information*
38 *technology systems that meet the requirements in subparagraph*
39 *(D) to retrieve information in the CURES database on behalf of*
40 *an authorized health care practitioner or pharmacist.*

1 (F) *The department shall not access patient-identifiable*
2 *information in an entity's health information technology system.*

3 ~~(F)~~

4 (G) *An entity that operates a health information technology*
5 *system that is requesting to establish an integration with the*
6 *CURES database shall: shall pay a reasonable fee to cover the*
7 *cost of establishing and maintaining integration with the CURES*
8 *database.*

9 ~~(i) Pay a reasonable fee to cover the cost of establishing and~~
10 ~~maintaining integration with the CURES database.~~

11 ~~(ii) Be subject to enforcement mechanisms for failure to comply~~
12 ~~with oversight or audit activities by the department, up to and~~
13 ~~including termination of access to the CURES database.~~

14 (H) *The department may prohibit integration or terminate a*
15 *health information technology system's ability to retrieve*
16 *information in the CURES database if the health information*
17 *technology system fails to meet the requirements of subparagraph*
18 *(D), or the entity operating the health information technology*
19 *system does not fulfill its obligation under subparagraph (G).*

20 (2) *A health care practitioner authorized to prescribe, order,*
21 *administer, furnish, or dispense Schedule II, Schedule III, or*
22 *Schedule IV controlled substances pursuant to Section 11150 or*
23 *a pharmacist shall be deemed to have complied with paragraph*
24 *(1) if the licensed health care practitioner or pharmacist has been*
25 *approved to access the CURES database through the process*
26 *developed pursuant to subdivision (a) of Section 209 of the*
27 *Business and Professions Code.*

28 (b) *A request for, or release of, a controlled substance history*
29 *pursuant to this section shall be made in accordance with guidelines*
30 *developed by the department.*

31 (c) *In order to prevent the inappropriate, improper, or illegal*
32 *use of Schedule II, Schedule III, or Schedule IV controlled*
33 *substances, the department may initiate the referral of the history*
34 *of controlled substances dispensed to an individual based on data*
35 *contained in CURES to licensed health care practitioners,*
36 *pharmacists, or both, providing care or services to the individual.*
37 ~~*An authorized health care practitioner may use a health information*~~
38 ~~*technology system, either on a user-initiated basis or an automated*~~
39 ~~*basis, to initiate the referral of the history of controlled substances*~~

1 dispensed to an individual based on data contained in CURES to
2 other licensed health care practitioners, pharmacists, or both.

3 (d) The history of controlled substances dispensed to an
4 individual based on data contained in CURES that is received by
5 a practitioner or pharmacist from the department pursuant to this
6 section is medical information subject to the provisions of the
7 Confidentiality of Medical Information Act contained in Part 2.6
8 (commencing with Section 56) of Division 1 of the Civil Code.

9 (e) Information concerning a patient's controlled substance
10 history provided to a practitioner or pharmacist pursuant to this
11 section shall include prescriptions for controlled substances listed
12 in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code
13 of Federal Regulations.

14 (f) A health care practitioner, pharmacist, and any person acting
15 on behalf of a health care practitioner or pharmacist, when acting
16 with reasonable care and in good faith, is not subject to civil or
17 administrative liability arising from any false, incomplete,
18 inaccurate, or misattributed information submitted to, reported by,
19 or relied upon in the CURES database or for any resulting failure
20 of the CURES database to accurately or timely report that
21 information.

22 (g) For purposes of this section, the following terms have the
23 following meanings:

24 (1) "Automated basis" means using predefined criteria
25 established or approved by a health care practitioner *or pharmacist*
26 to trigger an automated query to the CURES database, which can
27 be attributed to a specific health care practitioner ~~by an audit trail~~
28 ~~in the health information technology system.~~ *or pharmacist.*

29 (2) "Department" means the Department of Justice.

30 (3) "Health information technology system" means an
31 information processing application using hardware and software
32 for the storage, retrieval, sharing of or use of patient data for
33 communication, decisionmaking, coordination of care, or the
34 quality, safety, or efficiency of the practice of medicine or delivery
35 of health care services, including, but not limited to, electronic
36 medical record applications, health information exchange systems,
37 or other interoperable clinical or health care information system.

38 (4) "User-initiated basis" means an authorized health care
39 practitioner *or pharmacist* has taken an action to initiate the query
40 to the CURES database, such as clicking a button, issuing a voice

1 command, or taking some other action that can be attributed to a
2 specific health care practitioner ~~by an audit trail in the health~~
3 ~~information technology system.~~ *or pharmacist.*

4 SEC. 2. This act is an urgency statute necessary for the
5 immediate preservation of the public peace, health, or safety within
6 the meaning of Article IV of the California Constitution and shall
7 go into immediate effect. The facts constituting the necessity are:

8 In order to ensure that information in the CURES database is
9 available to prescribing physicians so they may prevent the
10 dangerous abuse of prescription drugs and to safeguard the health
11 and safety of the people of this state, it is necessary that this act
12 take effect immediately.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 148
Author: Mathis, E. Garcia, Gonzalez Fletcher, Dahle, and Lackey
Bill Date: July 17, 2017, Amended
Subject: California Physician Corps Program: Practice Setting
Sponsor: Author
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the definition of “practice setting” for purposes of eligibility under the Physician Corps Loan Repayment Program (Program), which includes the Steven M. Thompson Loan Repayment Program (STLRP) and the Physician Volunteer Program, for community clinics and physician offices by allowing settings to participate in the program if 30% of their patient population qualifies as medically underserved and if the setting is in a rural area. This bill would sunset the revised definition on January 1, 2020. This bill would require the Health Professions Education Foundation (HPEF) to prepare a study and reports to determine the effect this bill has on funding for loan repayments granted during 2018 and 2019.

BACKGROUND:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to \$105,000) in exchange for a minimum three years of service in the underserved area. In 2006, the administration of STLRP was transitioned from the Board to HPEF. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions’ students and recent graduates, these programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a \$25 fee paid by physicians and surgeons.

ANALYSIS

This bill would revise the definition of a practice setting for the purposes of Program eligibility to allow community clinics and physician offices that are in rural areas to be eligible if 30% of their patient population qualifies as medically underserved. This bill would sunset the revised practice setting definition on January 1, 2020. After January 1, 2020, physician offices would also be required to have a minimum of 50 percent of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

This bill would define a “rural area” as a medical service study area with a population density of fewer than 250 persons per square mile and no population center in excess of 50,000 within the area, as determined by the Office of Statewide Health Planning and Development.

The current practice setting definition specifies that community clinics and physician offices are eligible for the Program if 50% of their patient population qualifies as medically underserved. This bill only changes the definition for rural areas, all other areas still must meet the 50% threshold in order to be eligible. This bill would also specify that the revised definition only applies to program participants that enroll in the Program on or after January 1, 2018. After January 1, 2020, the practice setting definition would go back to the original practice setting definition, requiring all areas to meet the 50% medically underserved patient population requirement.

This bill would require HPEF to prepare a study to determine the effect of the revised practice setting definition in this bill on funding for loan repayments granted during the calendar years 2018 and 2019. By March 1, 2019, HPEF would be required to submit a report of the study to the Legislature, including program data for calendar year 2018, as compared to program data for calendar years 2016 and 2017. By March 1, 2020, HPEF would be required to submit a report of the study to the Legislature, including program data for calendar year 2019. The reports, at a minimum, would be required to identify all of the following:

- The name and location of all practice settings with program participants, with the practice settings disaggregated by type.
- The number of patients in a practice setting, disaggregated by type of area, including a rural area, among others, and the number of total patients in that practice setting.
- The number and amount of funding for loan repayments granted under the revised definition, disaggregated by type of program participants.

According to the author, rural areas struggle to incentivize quality physicians to take up residency in these areas, and this bill is designed to give rural areas a greater chance to obtain the benefits of the STLRP and recruit physicians to these areas. According to a report submitted by HPEF, only 15 of the total 126 STLRP awardees were in rural areas in 2015/16. Supporters of this bill state that access to high quality health care in rural areas is dependent upon an adequate supply of health care providers and loan repayment programs are a great way to attract high quality physicians with diverse qualifications. This bill has the potential to expand the number of rural practice settings eligible for this Program.

Although the Board supported the bill in 2013 that originally added the 50% medically underserved patient population requirement for practice settings, AB 565 (Salas, Chapter 378), it appears that some rural areas cannot meet this requirement and as a result are not eligible for the Program. This bill will not increase the funding for the Program, but it will expand eligibility for practice settings in rural areas until January 1, 2020, which may help to incentivize physicians to practice in those areas. For this reason, the Board has taken a neutral position on this bill.

FISCAL:

None

SUPPORT:

Adventist Health; Alliance of Catholic Health Care; Association of California Healthcare Districts; California Chapters of the American College of Physicians; California Commission on Aging; California Hospital Association; California Medical Association; Loma Linda University Health; Rural County Representatives of California; and Tenet Healthcare

OPPOSITION:

None on file

AMENDED IN SENATE JULY 17, 2017

AMENDED IN SENATE JUNE 26, 2017

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 148

**Introduced by Assembly Members Mathis, Eduardo Garcia,
Gonzalez Fletcher, Dahle, and Lackey
(Coauthors: Assembly Members Caballero, Cunningham, Friedman,
Gallagher, Waldron, and Wood)
(Coauthors: Senators Berryhill, Fuller, Galgiani, and Mendoza)**

January 10, 2017

An act to amend ~~Section 128552 of~~ *Sections 128552 and 128553 of,*
and to add and repeal Section 128557.5 of, the Health and Safety Code,
relating to physicians and surgeons, and making an appropriation
therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 148, as amended, Mathis. California Physician Corps Program:
practice setting.

Existing law establishes the Steven M. Thompson Physician Corps
Loan Repayment Program (program) in the California Physician Corps
Program within the Health Professions Education Foundation, which
provides financial incentives, including repayment of educational loans,
to a physician and surgeon who practices in a medically underserved
area, as defined. Existing law establishes the Medically Underserved
Account for Physicians, a continuously appropriated account, within
the Health Professions Education Fund, to primarily provide funding
for the ongoing operations of the program. Existing law requires the

foundation and the Office of Statewide Health Planning and Development to develop guidelines using specified criteria for selection and placement of applicants.

Existing law defines “practice setting,” for these purposes, to include a community clinic, as defined, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county’s role to serve its indigent population, that is located in a medically underserved area and at least 50% of whose patients are from a medically underserved population. Existing law also defines “practice setting,” for these purposes, to include a physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 50% of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250% of the federal poverty level.

This bill would instead require, for purposes of this definition, *only until January 1, 2020*, and only for program participants who enroll in the program on or after January 1, 2018, ~~as specified, and before January 1, 2020~~, that the clinic or the physician owned and operated medical practice setting have at least 30% of patients, if the area is ~~rural~~, *a rural area, as defined*, or at least 50% of patients, if the area is ~~urban~~, *not a rural area*, who are from the above-described populations. By expanding the authorization for the use of moneys in the Medically Underserved Account for Physicians, this bill would make an appropriation.

This bill would require the foundation to prepare a study to determine the effect that the revised definition has on funding for loan repayment granted under the program during the calendar years 2018 and 2019. The bill would require the foundation to submit 2 reports of the study by March 1, 2019, and March 1, 2020, respectively, including program data for certain years and identifying specified information.

This bill would also make conforming changes to related provisions.

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes.

State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 128552 of the Health and Safety Code
- 2 is amended to read:

1 128552. For purposes of this article, the following definitions
2 apply:

3 (a) “Account” means the Medically Underserved Account for
4 Physicians established within the Health Professions Education
5 Fund pursuant to this article.

6 (b) “Foundation” means the Health Professions Education
7 Foundation.

8 (c) “Fund” means the Health Professions Education Fund.

9 (d) “Medi-Cal threshold languages” means primary languages
10 spoken by limited-English-proficient (LEP) population groups
11 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal
12 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP
13 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal
14 beneficiaries residing in two contiguous ZIP Codes.

15 (e) “Medically underserved area” means an area defined as a
16 health professional shortage area in Part 5 of Subchapter A of
17 Chapter 1 of Title 42 of the Code of Federal Regulations or an
18 area of the state where unmet priority needs for physicians exist
19 as determined by the California Healthcare Workforce Policy
20 Commission pursuant to Section 128225.

21 (f) “Medically underserved population” means the Medi-Cal
22 program, Healthy Families Program, and uninsured populations.

23 (g) “Office” means the Office of Statewide Health Planning and
24 Development (OSHPD).

25 (h) “Physician Volunteer Program” means the Physician
26 Volunteer Registry Program established by the Medical Board of
27 California.

28 (i) “Practice setting,” for the purposes of this article only, means
29 either of the following:

30 (1) A community clinic as defined in subdivision (a) of Section
31 1204 and subdivision (c) of Section 1206, a clinic owned or
32 operated by a public hospital and health system, or a clinic owned
33 and operated by a hospital that maintains the primary contract with
34 a county government to fulfill the county’s role pursuant to Section
35 17000 of the Welfare and Institutions Code, which is located in a
36 medically underserved area and meets the following conditions:

37 (A) For program participants who enrolled in the program before
38 January 1, 2018, and who continue to participate in the program
39 on or after that date, the clinic has at least 50 percent of patients
40 who are from a medically underserved population.

1 (B) ~~For~~ *Until January 1, 2020, for program participants who*
2 *enroll in the program on or after January 1, 2018, and before*
3 *January 1, 2020, the clinic has at least 30 percent of patients, if*
4 *the area is ~~rural~~, a rural area, or at least 50 percent of patients, if*
5 *the area is ~~urban~~, not a rural area, who are from a medically*
6 *underserved population.*

7 (C) *Commencing January 1, 2020, for program participants*
8 *who enroll in the program on or after January 1, 2020, and for*
9 *program participants described in subparagraph (A) or (B), the*
10 *clinic has at least 50 percent of patients who are from a medically*
11 *underserved population.*

12 (2) A physician owned and operated medical practice setting
13 that provides primary care located in a medically underserved area
14 and meets the following conditions:

15 (A) For program participants who enrolled in the program before
16 January 1, 2018, and who continue to participate in the program
17 on or after that date, the medical practice setting has a minimum
18 of 50 percent of patients who are uninsured, Medi-Cal beneficiaries,
19 or beneficiaries of another publicly funded program that serves
20 patients who earn less than 250 percent of the federal poverty level.

21 (B) ~~For~~ *Until January 1, 2020, for program participants who*
22 *enroll in the program on or after January 1, 2018, and before*
23 *January 1, 2020, the medical practice setting has at least 30 percent*
24 *of patients, if the area is ~~rural~~, a rural area, or at least 50 percent*
25 *of patients, if the area is ~~urban~~, not a rural area, who are uninsured,*
26 *Medi-Cal beneficiaries, or beneficiaries of another publicly funded*
27 *program that serves patients who earn less than 250 percent of the*
28 *federal poverty level.*

29 (C) *Commencing January 1, 2020, for program participants*
30 *who enroll in the program on or after January 1, 2020, and for*
31 *program participants described in subparagraph (A) or (B), the*
32 *medical practice setting has a minimum of 50 percent of patients*
33 *who are uninsured, Medi-Cal beneficiaries, or beneficiaries of*
34 *another publicly funded program that serves patients who earn*
35 *less than 250 percent of the federal poverty level.*

36 (j) “Primary specialty” means family practice, internal medicine,
37 pediatrics, or obstetrics/gynecology.

38 (k) “Program” means the Steven M. Thompson Physician Corps
39 Loan Repayment Program.

1 (l) “Rural area” means a medical service study area with a
2 population density of fewer than 250 persons per square mile and
3 no population center in excess of 50,000 within the area, as
4 determined by the office.

5 ~~(t)~~

6 (m) “Selection committee” means a minimum three-member
7 committee of the board, that includes a member that was appointed
8 by the Medical Board of California.

9 SEC. 2. Section 128553 of the Health and Safety Code is
10 amended to read:

11 128553. (a) Program applicants shall possess a current valid
12 license to practice medicine in this state issued pursuant to Section
13 2050 of the Business and Professions Code or pursuant to the
14 Osteopathic Act.

15 (b) The foundation and the office shall develop guidelines using
16 the criteria specified in subdivision (c) for selection and placement
17 of applicants. The foundation shall interpret the guidelines to apply
18 to both osteopathic and allopathic physicians and surgeons.

19 (c) The guidelines shall meet all of the following criteria:

20 (1) Provide priority consideration to applicants that are best
21 suited to meet the cultural and linguistic needs and demands of
22 patients from medically underserved populations and who meet
23 one or more of the following criteria:

24 (A) Speak a Medi-Cal threshold language.

25 (B) Come from an economically disadvantaged background.

26 (C) Have received significant training in cultural and
27 linguistically appropriate service delivery.

28 (D) Have three years of experience providing health care
29 services to medically underserved populations or in a medically
30 underserved area, as defined in subdivision (e) of Section 128552.

31 (E) Have recently obtained a license to practice medicine.

32 (2) Include a process for determining the needs for physician
33 services identified by the practice setting and for ensuring that the
34 practice setting meets the definition specified in subdivision ~~(h)~~
35 (i) of Section 128552.

36 (3) Give preference to applicants who have completed a
37 three-year residency in a primary specialty.

38 (4) Give preference to applicants who agree to practice in a
39 medically underserved area, as defined in subdivision (e) of Section

1 128552, and who agree to serve a medically underserved
2 population.

3 (5) Give priority consideration to applicants from rural
4 communities who agree to practice in a physician owned and
5 operated medical practice setting as defined in paragraph (2) of
6 subdivision (i) of Section 128552.

7 (6) Include a factor ensuring geographic distribution of
8 placements.

9 (7) Provide priority consideration to applicants who agree to
10 practice in a geriatric care setting and are trained in geriatrics, and
11 who can meet the cultural and linguistic needs and demands of a
12 diverse population of older Californians. On and after January 1,
13 2009, up to 15 percent of the funds collected pursuant to Section
14 2436.5 of the Business and Professions Code shall be dedicated
15 to loan assistance for physicians and surgeons who agree to practice
16 in geriatric care settings or settings that primarily serve adults over
17 the age of 65 years or adults with disabilities.

18 (d) (1) The foundation may appoint a selection committee that
19 provides policy direction and guidance over the program and that
20 complies with the requirements of subdivision ~~(f)~~ (m) of Section
21 128552.

22 (2) The selection committee may fill up to 20 percent of the
23 available positions with program applicants from specialties outside
24 of the primary care specialties.

25 (e) Program participants shall meet all of the following
26 requirements:

27 (1) Shall be working ~~in~~ *in*, or have a signed agreement ~~with~~
28 *with*, an eligible practice setting.

29 (2) Shall have full-time status at the practice setting. Full-time
30 status shall be defined by the board and the selection committee
31 may establish exemptions from this requirement on a case-by-case
32 basis.

33 (3) Shall commit to a minimum of three years of service in a
34 medically underserved area. Leaves of absence shall be permitted
35 for serious illness, pregnancy, or other natural causes. The selection
36 committee shall develop the process for determining the maximum
37 permissible length of an absence and the process for reinstatement.
38 Loan repayment shall be deferred until the physician is back to
39 full-time status.

1 (f) The office shall adopt a process that applies if a physician
2 is unable to complete his or her three-year obligation.

3 (g) The foundation, in consultation with those identified in
4 subdivision (b) of Section 128551, shall develop a process for
5 outreach to potentially eligible applicants.

6 (h) The foundation may recommend to the office any other
7 standards of eligibility, placement, and termination appropriate to
8 achieve the aim of providing competent health care services in
9 approved practice settings.

10 *SEC. 3. Section 128557.5 is added to the Health and Safety*
11 *Code, to read:*

12 *128557.5. (a) The foundation shall prepare a study to*
13 *determine the effect that subparagraph (B) of paragraph (1) of,*
14 *and subparagraph (B) of paragraph (2) of, subdivision (i) of*
15 *Section 128552 have on funding for loan repayment granted under*
16 *this article during the calendar years 2018 and 2019.*

17 *(b) (1) (A) By March 1, 2019, the foundation shall submit a*
18 *report of the study described in subdivision (a) to the Legislature,*
19 *including program data for the calendar year 2018 as compared*
20 *to program data for the calendar years 2016 and 2017.*

21 *(B) By March 1, 2020, the foundation shall submit a report of*
22 *the study described in subdivision (a) to the Legislature, including*
23 *program data for the calendar year 2019.*

24 *(2) At a minimum, the reports described in paragraph (1) shall*
25 *identify all of the following:*

26 *(A) The name and location of all practice settings with program*
27 *participants, with the practice settings disaggregated by type as*
28 *defined in paragraphs (1) and (2) of subdivision (i) of Section*
29 *128552.*

30 *(B) The number of patients described in subparagraph (B) of*
31 *paragraph (1) of, or subparagraph (B) of paragraph (2) of,*
32 *subdivision (i) of Section 128552 in a practice setting,*
33 *disaggregated by type of area, including a rural area, among*
34 *others, and the number of total patients in that practice setting.*

35 *(C) The number and amount of funding for loan repayment*
36 *granted under this article, disaggregated by type of program*
37 *participants as described in paragraphs (1) and (2) of subdivision*
38 *(i) of Section 128552.*

- 1 (c) A report submitted pursuant to subdivision (b) shall be
2 submitted in compliance with Section 9795 of the Government
3 Code.
4 (d) Pursuant to Section 10231.5 of the Government Code, this
5 section shall become inoperative on March 1, 2024, and shall be
6 repealed on January 1, 2025.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 182
Author: Waldron
Bill Date: May 26, 2017, Amended
Subject: Heroin and Opioid Public Education Act
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the California Department of Public Health (CDPH), upon appropriation by the Legislature or receipt of adequate state or federal grant funding, to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the Heroin and Opioid Public Education (HOPE) Program, to combat the growing heroin and opioid medication epidemic in California. This bill would sunset the HOPE Program on January 1, 2023.

BACKGROUND:

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

The Medical Board of California (Board) developed a Prescribing Task Force that held multiple meetings to identify best practices, hear from speakers regarding this issue, and update the Board's Guidelines for Prescribing Controlled Substances for Pain. This task force had numerous meetings with interested parties and discussions with experts in the field of pain management to develop this document, which was adopted by the Board in November 2014. These Guidelines are intended to educate physicians on effective pain management in California by avoiding under treatment, overtreatment, or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. The Guidelines contain a significant amount of information and are supplemented with as many resources as practical via the appendices and links to websites that further assist a physician when prescribing controlled substances for pain. The Guidelines discuss several areas, including understanding pain, special patient populations, patient evaluation and risk stratification, consultation, treatment plan and objectives, patient

consent, pain management agreements, counseling patient on overdose risk and response, initiating an opioid trial, ongoing patient assessment, and several other areas.

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

ANALYSIS

This bill makes findings and declarations regarding the epidemic in California stemming from the use of heroin and the abuse of opioid medications and the need for awareness and dissemination of information. This bill would require CDPH, upon appropriation by the Legislature or receipt of adequate state or federal grant funding, to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the HOPE Program, to combat the growing heroin and opioid medication epidemic in California. This bill would sunset the HOPE Program on January 1, 2023.

This bill would require the HOPE Program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information using appropriate types of media, including new technologies in media, print media, television and radio, and Internet and social media. This dissemination of information shall focus on the following:

- Identifying the pathways that can lead to opioid medication abuse and heroin use.
- Showing the many faces of addiction and rebutting the commonly accepted myths and stereotypes about heroin users and opioid medication abusers.
- Educating the public on the negative impact of abuse and diversion of opioid medication, while recognizing the legitimate use of opioids.
- Describing the effects and warning signs of heroin use and opioid medication abuse to enable members of the public to know when help is needed.
- Showing the link that exists between heroin and opioid medication addiction and suicidal behavior.

- Identifying pathways that are available for individuals to seek help, and indicating telephone hotline systems for persons who wish to report cases of drug abuse or engage in substance abuse treatment.
- Highlighting the availability of naloxone hydrochloride as a means to avert death from a heroin or opioid medication overdose, identifying pathways for members of the public to obtain naloxone and training, and promoting the proper use of naloxone.
- Highlighting the benefits of substance abuse treatment.
- Highlighting the benefits of medication-assisted therapy using medications approved by the federal Food and Drug Administration, such as methadone, buprenorphine, extended-release injectable naltrexone, or other similar drugs, and destigmatizing the use of the medication-assisted therapy.
- Identifying the methods that can be used by an individual to help finance the costs of substance abuse treatment.
- Identifying the steps that individuals can take to prevent and deter others from misusing opioid medications.
- Identifying the proper methods for safeguarding and disposing of opioid medications.
- Addressing any other issue that CDPH may deem appropriate and necessary to proactively educate the public about the state's heroin or opioid medication addition.

In disseminating this information, the HOPE program shall employ a variety of complementary educational themes and messages that shall be tailored to appeal to different target audiences. At a minimum, the HOPE program shall incorporate all of the following:

- At least one message directed at individuals who are personally at risk of heroin use or opioid medication abuse or who have already started down a pathway of addiction.
- At least one message directed at family members and friends of addicted persons, teachers, school nurses, medical practitioners, and employers.
- At least one message that is directed at the dangers of teen drug pilfering from the household medicine cabinet and how this could be avoided through the use of safe storage products.

This bill would require information under the HOPE Program to be disseminated using culturally and linguistically appropriate means, and when feasible and appropriate, the information shall be made available in a variety of languages.

This bill would allow CDPH to enter into public-private partnerships with pharmaceutical or health care insurance companies, nonprofit social services organizations, mental health service providers and clinics, law enforcement, health care agencies, and school districts, that provide services in the state in order to facilitate the dissemination of information under the HOPE Program.

This bill would require CDPH to submit a report to the Governor and the Legislature on at least an annual basis that summarizes the actions undertaken by CDPH to implement

this bill and to include an assessment of the effectiveness of the HOPE Program, including, but not limited to, effects on the rate of new opioid and heroin addictions by populations, mitigation of the effects of opioid or heroin addiction, crime rates, hospitalization rates, death rates, and other calculable results as determined by CDPH. The report shall provide any recommendations for legislative or executive action that may be necessary to facilitate the ongoing success of the HOPE Program.

According to the author, there is an epidemic in California of heroin use stemming from the abuse of opioid medications and this epidemic demands our attention. The author believes that in order for California to combat this epidemic, citizens must be armed with information that will allow them to recognize and undertake appropriate actions when they or their loved ones are at risk of succumbing to a heroin or opioid medication addiction.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will increase awareness and provide education to help prevent heroin use and opioid medication abuse. This bill furthers the Board’s mission of consumer protection; as such, the Board supports this bill.

<u>FISCAL:</u>	None to the Board
<u>SUPPORT:</u>	American Academy of Pediatrics, California Biocom California Police Chiefs Association California State Parent Teacher Association California Special Districts Association Gatekeeper Innovation
<u>OPPOSITION:</u>	None on file
<u>POSITION:</u>	Recommendation: Support

AMENDED IN ASSEMBLY MAY 26, 2017
AMENDED IN ASSEMBLY MARCH 23, 2017
AMENDED IN ASSEMBLY MARCH 9, 2017
CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 182

Introduced by Assembly Member Waldron
(Coauthors: Assembly Members Baker, Mayes, and Wood)
(Coauthors: Senators Bates and Glazer)

January 19, 2017

An act to add *and repeal* Article 5 (commencing with Section 11774) ~~to~~ of Chapter 1 of Part 2 of Division 10.5 of the Health and Safety Code, relating to drug abuse.

LEGISLATIVE COUNSEL'S DIGEST

AB 182, as amended, Waldron. Heroin and Opioid Public Education (HOPE) Act.

~~Existing law vests the State Department of Health Care Services with duties, powers, purposes, functions, responsibilities, and jurisdiction of alcohol and drug programs in the state, including narcotic treatment programs that use narcotic replacement therapy for maintenance or detoxification of opioid medication dependence. Existing law requires the department to develop and implement a statewide prevention campaign designed to deter the abuse of methamphetamine in California, and authorizes the department to develop and implement a mass media alcohol and other drug education program in order to provide community education, develop public awareness, and motivate community action in alcohol and other drug abuse prevention, treatment, and rehabilitation.~~

Existing law tasks the State Department of Public Health with certain specified duties related to health information and strategic planning, including opioid misuse and overdose prevention. Among other duties, existing law directs the department, upon appropriation by the Legislature, to award naloxone grant funding to local health departments, local government agencies, or other entities, as specified, in order to reduce the rate of fatal overdose from opioid drugs including heroin and prescription opioids.

This bill would require the department, in consultation with stakeholders, to develop, coordinate, implement, and oversee a comprehensive multicultural public awareness campaign, to be known as “Heroin and Opioid Public Education—(HOPE).” *(HOPE),” upon appropriation by the Legislature or receipt of state or federal grant funding, until January 1, 2023.* The bill would require the HOPE program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information that ~~is designed to, focuses on, among other things, describe describing~~ the effects and warning signs of heroin use and opioid medication abuse, ~~so as to better enable members of the public to determine when help is needed and identify the~~ *and identifying available* pathways ~~that are available for individuals to seek~~ *seeking* help. The bill would require the HOPE program to effectuate the dissemination of information by using appropriate types of media, as specified, employing a variety of complementary educational themes and messages that are tailored to appeal to different target audiences, and using culturally and linguistically appropriate means.

The bill would require the department to submit a report to the Governor and Legislature on at least an annual basis, that summarizes the actions that have been undertaken by the department to implement the bill and includes an assessment of the effectiveness of the HOPE program, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. This act shall be known, and may be cited, as the
- 2 “HOPE Act.”

SEC. 2. Article 5 (commencing with Section 11774) is added to Chapter 1 of Part 2 of Division 10.5 of the Health and Safety Code, to read:

Article 5. Heroin and Opioid Public Education (HOPE)

11774. The Legislature finds and declares all of the following:

(a) There is an epidemic in this state stemming from the use of heroin and the abuse of opioid medications.

(b) Prescription drug overdoses now kill more people than car accidents.

(c) Every day, 2,500 children 12 to 17, inclusive, years of age abuse a prescription painkiller for the first time, and more people are becoming addicted to prescription drugs.

(d) Data from the federal Centers for Disease Control and Prevention suggests that the nonmedical use of prescription painkillers costs public and private health insurers seventy-two billion eight hundred million dollars (\$72,800,000,000) annually.

~~(b)~~

(e) In order for the state to combat this epidemic, citizens in all walks of life shall be alerted to the problem, and shall be armed with information that will allow them to recognize, and undertake appropriate actions, when they or their loved ones are at risk of, or are succumbing to, a heroin or opioid medication addiction.

~~(e)~~

(f) The widespread dissemination of information necessary to combat the state's heroin and opioid medication epidemic could be successfully achieved through the institution and maintenance of a multicultural statewide public awareness campaign, which would be carefully coordinated through all available multimedia channels to reach a wide variety of audiences, including drug users, their family members and friends, medical practitioners and nurses, emergency personnel, and employers.

~~(d) Prescription drug overdoses now kill more people than car accidents.~~

~~(e) Every day, 2,500 children 12 to 17 years of age abuse a prescription painkiller for the first time, and more people are becoming addicted to prescription drugs.~~

~~(f) Data from the federal Centers for Disease Control and Prevention suggests that the nonmedical use of prescription~~

~~1 painkillers costs public and private health insurers seventy-two~~
~~2 billion eight hundred million dollars (\$72,800,000,000) annually.~~

~~3 (g) As abuse rates have risen, the functions of the State~~
~~4 Department of Alcohol and Drug Programs have been transferred~~
~~5 to the State Department of Health Care Services.~~

~~6 (h) In order to be more successful in combating drug abuse,~~
~~7 while addressing the current opioid and heroin epidemic, the~~
~~8 department's current public awareness campaign is being used to~~
~~9 combat the state's growing heroin and opioid medication epidemic~~
~~10 shall be designed to do all of the following:~~

~~11 (1) Educate the public as to the reasons why ordinary people~~
~~12 may engage in the abuse of opioid medications and the associated~~
~~13 use of heroin.~~

~~14 (2) Rebut the commonly accepted myths and stereotypes~~
~~15 associated with heroin use and opioid medication abuse.~~

~~16 (3) Stigmatize and condemn the abuse and diversion of opioid~~
~~17 medication, while still recognizing the legitimate use of those~~
~~18 opioid drugs as medications.~~

~~19 11774.1. (a) The department,~~ *The State Department of Public*
~~20 Health, upon appropriation by the Legislature or receipt of~~
~~21 adequate state or federal grant funding, and in consultation with~~
~~22 stakeholders, as appropriate, shall develop, coordinate, implement,~~
~~23 and oversee a comprehensive multicultural public awareness~~
~~24 campaign, to be known as "Heroin and Opioid Public Education~~
~~25 (HOPE)," which shall allow for the coordinated and widespread~~
~~26 dissemination of information designed to combat the growing~~
~~27 heroin and opioid medication epidemic in the state.~~

~~28 (b) Using the means described in subdivision (c), HOPE shall~~
~~29 provide for the coordinated and widespread public dissemination~~
~~30 of individual case stories and other generalized information that~~
~~31 is designed to do all focuses on any of the following:~~

~~32 (1) Identify~~ *Identifying* the pathways that can lead to opioid
~~33 medication abuse and heroin use, and the reasons why opioid~~
~~34 medication abuse may evolve into heroin use.~~

~~35 (2) Show~~ *Showing* the many faces of heroin and opioid
~~36 medication addiction, and rebut~~ *rebutting* the commonly accepted
~~37 myths and stereotypes about heroin users and opioid medication~~
~~38 abusers.~~

~~39 (3) Condemn and stigmatize~~ *Educating the public on the*
~~40 negative impact of abuse and diversion of opioid medication, while~~

1 recognizing the legitimate use of those same opioid drugs as
2 medications.

3 (4) ~~Describe~~ *Describing* the effects and warning signs of heroin
4 use and opioid medication abuse, so as to better enable members
5 of the public to determine when help is needed.

6 (5) ~~Show~~ *Showing* the link that exists between heroin and opioid
7 medication addiction and suicidal behavior.

8 (6) ~~Identify~~ *Identifying* the pathways that are available for
9 individuals to seek help in association with their own, or another
10 person's, heroin or opioid medication addiction, and ~~indicate~~
11 *indicating* the various telephone hotline systems that exist in the
12 state for persons who wish to report a case of drug abuse or engage
13 in substance abuse treatment.

14 (7) ~~Highlight~~ *Highlighting* the availability of naloxone
15 hydrochloride as a means to avert death from a heroin or opioid
16 medication overdose, ~~identify~~ *identifying* pathways for members
17 of the public to obtain a prescription for naloxone hydrochloride
18 and training in the emergency administration of naloxone
19 hydrochloride, and ~~promote~~ *promoting* the proper use of naloxone
20 hydrochloride in crisis situations.

21 (8) ~~Highlight~~ *Highlighting* the benefits of substance abuse
22 treatment and the potential for treatment to allow for the reclaiming
23 of lives that have been upset by addiction, and ~~underscore~~
24 *underscoring* the fact that relapses occur not because treatment is
25 ineffective, but because of the nature of addiction, which is a
26 recurring and relapsing disorder.

27 (9) ~~Highlight~~ *Highlighting* the benefits of medication-assisted
28 therapy using medications approved by the federal Food and Drug
29 Administration, such as methadone, buprenorphine,
30 extended-release injectable naltrexone, or other similar drugs, and
31 ~~destigmatize~~ *destigmatizing* the use of that medication-assisted
32 therapy.

33 (10) ~~Identify~~ *Identifying* the methods that can be used by an
34 individual to help finance the costs of substance abuse treatment.

35 (11) ~~Identify~~ *Identifying* the steps that individuals can take to
36 prevent and deter family members, friends, students, patients,
37 coworkers, and others from first experimenting with inappropriately
38 obtained opioid medications, and from misusing or mismanaging
39 lawful opioid medications.

1 (12) ~~Identify~~ *Identifying* the proper methods for safeguarding,
2 and for safely disposing of, legitimate opioid medications.

3 (13) ~~Address~~ *Addressing* any other issues that the department
4 may deem appropriate and necessary to proactively educate the
5 public about the state's heroin and opioid medication epidemic
6 and the actions that can be taken by members of the public to
7 reduce the likelihood of heroin or opioid medication addiction, or
8 to otherwise respond to, or mitigate the effects of, heroin or opioid
9 medication addiction in cases in which it is present.

10 (c) (1) The HOPE program shall effectuate the dissemination
11 of information described in subdivision (b) by using appropriate
12 types of media to achieve the goal efficiently and effectively,
13 including new technologies in media, print media, television and
14 radio, *and* Internet and social media.

15 (2) In disseminating the information described in subdivision
16 (b), the HOPE program shall employ a variety of complementary
17 educational themes and messages that shall be tailored to appeal
18 to different target audiences in the state. At a minimum, the HOPE
19 program shall incorporate all of the following:

20 (A) At least one message that is directed at, and is tailored to
21 influence and resonate with, individuals who are personally at risk
22 of heroin use or opioid medication abuse or who have already
23 started down a pathway to addiction.

24 (B) At least one message that is directed at, and is tailored to
25 influence and resonate with, the family members and friends of
26 addicted persons, teachers, school nurses, medical practitioners,
27 and employers.

28 (C) At least one message that is directed at the dangers of teen
29 drug pilfering from the household medicine cabinet and how this
30 could be avoided through the use of safe storage products.

31 (3) Information under the HOPE program shall be disseminated
32 using culturally and linguistically appropriate means, in a manner
33 that demonstrates respect for individual dignity and cultural
34 differences. Where feasible and appropriate, the information shall
35 be made available in a variety of languages.

36 (4) The department may enter into public-private partnerships
37 with pharmaceutical or health care insurance companies, nonprofit
38 social services organizations, mental health services providers and
39 clinics, law enforcement, health care agencies, and school districts,

1 that provide services in the state in order to facilitate the
2 dissemination of information under the HOPE program.

3 11774.2. (a) The department shall submit to the Governor and
4 the Legislature on at least an annual basis, a report that summarizes
5 the actions that have been undertaken by the department to
6 implement this article and includes an assessment of the
7 effectiveness of the program, including, but not limited to, effects
8 on the rate of new opioid and heroin addictions by populations,
9 mitigation of the effects of opioid or heroin addiction, crime rates,
10 hospitalization rates, death rates, and other calculable results as
11 determined by the department. The report shall provide any
12 recommendations for legislative or executive action that may be
13 necessary to facilitate the ongoing success of the program.

14 (b) A report to be submitted to the Legislature pursuant to this
15 section shall be submitted in compliance with Section 9795 of the
16 Government Code.

17 11774.3. The department may adopt regulations in accordance
18 with the rulemaking provisions of the Administrative Procedure
19 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of
20 Division 3 of Title 2 of the Government Code) as necessary to
21 implement this article.

22 11774.4. *This article shall remain in effect only until January*
23 *1, 2023, and as of that date is repealed, unless a later enacted*
24 *statute, that is enacted before January 1, 2023, deletes or extends*
25 *that date.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 443
Author: Salas
Bill Date: July 5, 2017, Amended
Subject: Optometry: Scope of Practice
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would expand the scope of practice for optometrists to include the ability to provide habilitative services, provide for more independent practice, treat additional conditions, and administer vaccines.

BACKGROUND:

The Optometry Practice Act (Act) provides for the licensure and regulation of the practice of optometry by the California Board of Optometry (CBO), which is within the Department of Consumer Affairs. That act provides that the practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain activities, including, but not limited to, the examination of the human eye or eyes.

Per the committee analysis:

“An optometrist (Doctor of Optometry or O.D.) is an independent primary health care professional for the eye. Optometrists examine, diagnose, treat, and manage diseases, injuries, and disorders of the visual system, the eye, and associated structures, as well as identify related systemic conditions affecting the eye. ODs prescribe medications, low vision rehabilitation, vision therapy, spectacle lenses, contact lenses, and perform certain surgical procedures.

“Optometrists have a narrower scope of practice than do ophthalmologists, but are held to the identical standard of care for the same treatments they provide. An O.D. degree requires both an undergraduate education in a college or university and four years of professional education at a college of optometry. Some optometrists also undertake an optional one year non-surgical residency program to enhance their experience in a particular area. Students graduate with 2,500-3,000 patient encounters; these include a mix of post-surgical, medical and routine visits.

“In order to be licensed to practice by the California Board of Optometry, an individual must obtain an O.D. degree, pass the three part National Board of Examiners in Optometry examination, and the California Optometric State Law Examination. There are currently 9,100 optometrists in practice in California.”

ANALYSIS:

This bill would do the following:

- Allow an optometrist to provide habilitative optometric services.
- Remove provisions in existing law that require optometrists to refer specified cases and consult on specified cases with an ophthalmologist or appropriate physician.
- Replace the terms “corneal surface disease and dry eyes” with “nonmalignant ocular surface disease and dry eye disease” as conditions that an optometrist is authorized to diagnose and treat.
- Add hypotrichosis and blepharitis to the list of conditions that an optometrist is authorized to diagnose and treat.
- Authorize an optometrist to prescribe specified therapeutic pharmaceutical agents, including for off-label use. Would also add tramadol to the list of therapeutic pharmaceutical agents an optometrist may use and prescribe.
- Delete the requirement that an optometrist must maintain a written record in the patient’s file of information provided to a patient’s ophthalmologist, the ophthalmologist’s response, and any other relevant information in cases for which an optometrist must consult with an ophthalmologist. Would also delete the requirement that this information must be provided upon request of the ophthalmologist with the consent of the patient.
- Authorize an optometrist to collect blood by skin puncture for testing patients suspected of having diabetes.
- Authorize an optometrist to perform skin testing to diagnose ocular allergies, limited to the superficial layer of the skin.
- Authorize an optometrist to use or prescribe diagnostic contact lenses.
- Authorize an optometrist to use a needle to remove foreign bodies from the cornea, eyelid, and conjunctiva.
- Revise the qualifications for an optometrist to be certified to treat glaucoma in patients over 18 years of age for optometrists that completed a didactic course of no less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, these optometrists now must submit proof of satisfactory completion of the case management requirements for certification established by the CBO.
- Authorize an optometrist, as specified, to use any topical or oral therapeutic pharmaceutical agent, which is not a controlled substance, or noninvasive medical device, or technology whose use does not constitute surgery that is not expressly authorized for use or prescription by an optometrist certified to use therapeutic pharmaceutical agents, if it has received a United States Food and Drug Administration approved indication for the diagnosis or treatment of a condition authorized by the Act. An optometrist shall successfully complete any clinical training imposed by a related manufacturer prior to using any of those therapeutic pharmaceutical agents or noninvasive medical devices or technologies.
- Authorize an optometrist, as specified, to use any other topical or oral therapeutic pharmaceutical agent which is not a controlled substance, or noninvasive medical device, or technology whose use does not constitute surgery, that is not expressly

authorized for use or prescription by an optometrist certified to use therapeutic pharmaceutical agents and does not meet other requirements, as specified, if approved by the CBO through regulation for the rational treatment of a condition authorized by the Act. Any regulation pursuant to this paragraph shall require a licensee to successfully complete an appropriate amount of clinical training to qualify to use each topical or oral therapeutic pharmaceutical agent or noninvasive medical device or technology approved by the CBO pursuant to this paragraph.

- Prohibit an optometrist from using injections for cosmetic effect and the performance of blepharoplasty or other cosmetic surgery procedures that reshape the normal structures of the body in order to improve appearance and self-esteem.
- Allow an optometrist who meets specified certification requirements to also be certified to administer immunizations after the optometrist meets all of the following requirements:
 - Completes an immunization training program endorsed by the Centers for Disease Control and Prevention (CDC) that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintains that training.
 - Is certified in basic life support.
 - Complies with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the Immunization Branch of the California Department of Public Health.
 - Applies for an immunization certificate on a CBO approved form.
 - Pays the application fee for a certificate to administer immunizations, which shall not exceed \$50.
- Define immunization as the administration of immunizations for influenza, herpes zoster virus, and pneumococcus in compliance with individual Advisory Committee on Immunization Practices (ACIP) vaccine recommendations published by CDC for persons 18 years of age or older.
- Specify that the definition of surgery in the Act does not include the provisions added by this bill.
- Add "steroid induced glaucoma" to the definition of glaucoma and would require an optometrist who treats a patient for steroid induced glaucoma to promptly notify the prescriber of the steroid medication if the prescriber did not refer the patient to the optometrist for treatment.
- Require an optometrist to consult with and, if necessary, refer to a physician or other appropriate health care provider when a situation or condition occurs that is beyond the optometrist's scope of practice. Consultations, referrals, and notifications required by this section shall be documented in the patient record.
- Specify that failure to refer a patient to an appropriate physician constitutes unprofessional conduct.
- Make other non-substantive, technical, clarifying changes.

According to the author, this bill seeks to expand the optometrist's scope of practice to allow optometrist to examine, prevent, diagnose, and treat certain conditions and disorders of the visual system and the human eye to the full extent of their training. The language in this bill has been negotiated with stakeholders to include noninvasive, nonsurgical technology to treat conditions authorized by the Optometric Act. It also streamlines protocols and allows optometrists to administer certain vaccines.

According to the Optometric Association, the only outstanding issue is the question of what additional clinical training should be required before optometrists can use lasers and perform minor procedures, which was language included in last year's SB 622. All stakeholders have worked hard to negotiate the language that is currently in AB 443.

The National Vaccine Center is in opposition to this bill and states that optometrists are not doctors and vaccines have nothing to do with the eyes. They do not believe that vaccine administration should be performed by optometrists.

This bill has been significantly amended and narrowed, compared to SB 492 from 2014 and SB 622 from 2016. This bill does add conditions that can be treated by an optometrist, authorizes optometrists to prescribe additional topical or oral therapeutic pharmaceutical agents, removes requirements for consultation/referral to appropriate physicians or ophthalmologists, and allows optometrists to administer vaccinations. This bill still expands the scope of optometrists without requiring any additional training or education. Allowing optometrists to perform these additional procedures, diagnose and treat more conditions and prescribe additional topical or oral therapeutic pharmaceutical agents may result in consumer harm if the optometrist does not have the proper training and education. Board staff suggests that the Board oppose this bill unless it is amended to require additional training and/or education related to the optometrist scope expansions included in this bill.

FISCAL: None

SUPPORT: California Optometric Association
VSP Vision Care
Numerous Individuals

OPPOSITION: National Vaccine Information Center
Voice for Choice Advocacy
Numerous Individuals

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE JULY 5, 2017
AMENDED IN ASSEMBLY MAY 2, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 443

Introduced by Assembly Member Salas

February 13, 2017

An act to amend Sections 1209, 3041, 3041.1, 3041.2, 3041.3, 3056, 3057, 3110, and 3152 of the Business and Professions Code, relating to healing arts, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 443, as amended, Salas. Optometry: scope of practice.

The Optometry Practice Act provides for the licensure and regulation of the practice of optometry by the State Board of Optometry, which is within the Department of Consumer Affairs. That act provides that the practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eye or eyes. Existing law makes a violation of the act punishable as a crime.

This bill would revise the scope of the practice of optometry by, among other things, providing that the practice of optometry includes the provision of habilitative optometric services.

~~Existing law authorizes an optometrist who meets certain requirements, including, but not limited to, completing a preceptorship of 65 hours and a minimum of 100 hours of directed and accredited~~

~~education in ocular and systemic diseases, to use therapeutic pharmaceutical agents. Existing law authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified conditions and perform certain procedures.~~

~~This bill would delete the requirement of 100 hours of directed and accredited study and would instead require, except as specified, an optometrist to satisfactorily complete and pass an examination in a didactic course of no more than 80 classroom hours in the diagnosis, pharmacological, and other treatment and management of ocular disease provided at an accredited school of optometry in the state or an accredited ophthalmology residency program in the state and 20 hours of self-directed education. The bill would require the preceptorship of 65 hours to be completed in either an ophthalmologist's office or an optometric clinic and would require the preceptor to be an ophthalmologist licensed by and in good standing with the Medical Board of California.~~

The bill would additionally authorize an optometrist who is certified to use therapeutic pharmaceutical agents to, among other things, perform skin testing to diagnose ocular allergies and to treat and diagnose hypotrichosis and blepharitis. The bill would authorize an optometrist certified to use therapeutic pharmaceutical agents to administer immunizations if the optometrist meets certain requirements, including that the optometrist is certified in basic life support.

Existing law requires an optometrist to consult with and refer a patient to an ophthalmologist or a physician and surgeon in certain circumstances, including if a patient has a recurrent case of peripheral corneal inflammatory keratitis within one year of the initial occurrence.

This bill would instead require an optometrist to consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider when a situation or condition occurs that is beyond the optometrist's scope of practice. *The bill would require all consultations, referrals, and notifications be documented in the patient record.* By changing the definition of an existing crime, this bill would impose a state-mandated local program.

Existing law requires all moneys collected pursuant to the act, except fine and penalty money, to be deposited in the Optometry Fund and continuously appropriated to the board to carry out the act.

This bill would require an applicant for a certificate to administer immunizations to pay a fee not to exceed \$50. Because this bill would

increase those moneys deposited in a continuously appropriated fund, it would make an appropriation.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: yes. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1209 of the Business and Professions
2 Code is amended to read:
3 1209. (a) As used in this chapter, “laboratory director” means
4 any person who is any of the following:
5 (1) A duly licensed physician and surgeon.
6 (2) Only for purposes of a clinical laboratory test or examination
7 classified as waived, is any of the following:
8 (A) A duly licensed clinical laboratory scientist.
9 (B) A duly licensed limited clinical laboratory scientist.
10 (C) A duly licensed naturopathic doctor.
11 (D) A duly licensed optometrist serving as the director of a
12 laboratory that only performs clinical laboratory tests authorized
13 in paragraph (10) of subdivision (d) of Section 3041.
14 (3) Licensed to direct a clinical laboratory under this chapter.
15 (b) (1) A person defined in paragraph (1) or (3) of subdivision
16 (a) who is identified as the CLIA laboratory director of a laboratory
17 that performs clinical laboratory tests classified as moderate or
18 high complexity shall also meet the laboratory director
19 qualifications under CLIA for the type and complexity of tests
20 being offered by the laboratory.
21 (2) As used in this subdivision, “CLIA laboratory director”
22 means the person identified as the laboratory director on the CLIA
23 certificate issued to the laboratory by the federal Centers for
24 Medicare and Medicaid Services (CMS).
25 (c) The laboratory director, if qualified under CLIA, may
26 perform the duties of the technical consultant, technical supervisor,
27 clinical consultant, general supervisor, and testing personnel, or
28 delegate these responsibilities to persons qualified under CLIA.

1 If the laboratory director reapportions performance of those
2 responsibilities or duties, he or she shall remain responsible for
3 ensuring that all those duties and responsibilities are properly
4 performed.

5 (d) (1) The laboratory director is responsible for the overall
6 operation and administration of the clinical laboratory, including
7 administering the technical and scientific operation of a clinical
8 laboratory, the selection and supervision of procedures, the
9 reporting of results, and active participation in its operations to
10 the extent necessary to ensure compliance with this act and CLIA.
11 He or she shall be responsible for the proper performance of all
12 laboratory work of all subordinates and shall employ a sufficient
13 number of laboratory personnel with the appropriate education
14 and either experience or training to provide appropriate
15 consultation, properly supervise and accurately perform tests, and
16 report test results in accordance with the personnel qualifications,
17 duties, and responsibilities described in CLIA and this chapter.

18 (2) Where a point-of-care laboratory testing device is utilized
19 and provides results for more than one analyte, the testing
20 personnel may perform and report the results of all tests ordered
21 for each analyte for which he or she has been found by the
22 laboratory director to be competent to perform and report.

23 (e) As part of the overall operation and administration, the
24 laboratory director of a registered laboratory shall document the
25 adequacy of the qualifications (educational background, training,
26 and experience) of the personnel directing and supervising the
27 laboratory and performing the laboratory test procedures and
28 examinations. In determining the adequacy of qualifications, the
29 laboratory director shall comply with any regulations adopted by
30 the department that specify the minimum qualifications for
31 personnel, in addition to any CLIA requirements relative to the
32 education or training of personnel.

33 (f) As part of the overall operation and administration, the
34 laboratory director of a licensed laboratory shall do all of the
35 following:

36 (1) Ensure that all personnel, prior to testing biological
37 specimens, have the appropriate education and experience, receive
38 the appropriate training for the type and complexity of the services
39 offered, and have demonstrated that they can perform all testing
40 operations reliably to provide and report accurate results. In

determining the adequacy of qualifications, the laboratory director shall comply with any regulations adopted by the department that specify the minimum qualifications for, and the type of procedures that may be performed by, personnel in addition to any CLIA requirements relative to the education or training of personnel. Any regulations adopted pursuant to this section that specify the type of procedure that may be performed by testing personnel shall be based on the skills, knowledge, and tasks required to perform the type of procedure in question.

(2) Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and postanalytical phases of testing to ensure that they are competent and maintain their competency to process biological specimens, perform test procedures, and report test results promptly and proficiently, and, whenever necessary, identify needs for remedial training or continuing education to improve skills.

(3) Specify in writing the responsibilities and duties of each individual engaged in the performance of the preanalytic, analytic, and postanalytic phases of clinical laboratory tests or examinations, including which clinical laboratory tests or examinations the individual is authorized to perform, whether supervision is required for the individual to perform specimen processing, test performance, or results reporting, and whether consultant, supervisor, or director review is required prior to the individual reporting patient test results.

(g) The competency and performance of staff of a licensed laboratory shall be evaluated and documented by the laboratory director, or by a person who qualifies as a technical consultant or a technical supervisor under CLIA depending on the type and complexity of tests being offered by the laboratory.

(1) The procedures for evaluating the competency of the staff shall include, but are not limited to, all of the following:

(A) Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen handling, processing, and testing.

(B) Monitoring the recording and reporting of test results.

(C) Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records.

1 (D) Direct observation of performance of instrument
2 maintenance and function checks.

3 (E) Assessment of test performance through testing previously
4 analyzed specimens, internal blind testing samples, or external
5 proficiency testing samples.

6 (F) Assessment of problem solving skills.

7 (2) Evaluation and documentation of staff competency and
8 performance shall occur at least semiannually during the first year
9 an individual tests biological specimens. Thereafter, evaluations
10 shall be performed at least annually unless test methodology or
11 instrumentation changes, in which case, prior to reporting patient
12 test results, the individual's performance shall be reevaluated to
13 include the use of the new test methodology or instrumentation.

14 (h) The laboratory director of each clinical laboratory of an
15 acute care hospital shall be a physician and surgeon who is a
16 qualified pathologist, except as follows:

17 (1) If a qualified pathologist is not available, a physician and
18 surgeon or a clinical laboratory bioanalyst qualified as a laboratory
19 director under subdivision (a) may direct the laboratory. However,
20 a qualified pathologist shall be available for consultation at suitable
21 intervals to ensure high-quality service.

22 (2) If there are two or more clinical laboratories of an acute care
23 hospital, those additional clinical laboratories that are limited to
24 the performance of blood gas analysis, blood electrolyte analysis,
25 or both, may be directed by a physician and surgeon qualified as
26 a laboratory director under subdivision (a), irrespective of whether
27 a pathologist is available.

28 As used in this subdivision, a qualified pathologist is a physician
29 and surgeon certified or eligible for certification in clinical or
30 anatomical pathology by the American Board of Pathology or the
31 American Osteopathic Board of Pathology.

32 (i) Subdivision (h) does not apply to any director of a clinical
33 laboratory of an acute care hospital acting in that capacity on or
34 before January 1, 1988.

35 (j) A laboratory director may serve as the director of up to the
36 maximum number of laboratories stipulated by CLIA, as defined
37 under Section 1202.5.

38 SEC. 2. Section 3041 of the Business and Professions Code is
39 amended to read:

1 3041. (a) The practice of optometry includes the prevention
2 and diagnosis of disorders and dysfunctions of the visual system,
3 and the treatment and management of certain disorders and
4 dysfunctions of the visual system, as well as the provision of
5 habilitative or rehabilitative optometric services, and is the doing
6 of any or all of the following:

7 (1) The examination of the human eye or eyes, or its or their
8 appendages, and the analysis of the human vision system, either
9 subjectively or objectively.

10 (2) The determination of the powers or range of human vision
11 and the accommodative and refractive states of the human eye or
12 eyes, including the scope of its or their functions and general
13 condition.

14 (3) The prescribing or directing the use of, or using, any optical
15 device in connection with ocular exercises, visual training, vision
16 training, or orthoptics.

17 (4) The prescribing of contact and spectacle lenses for, or the
18 fitting or adaptation of contact and spectacle lenses to, the human
19 eye, including lenses that may be classified as drugs or devices by
20 any law of the United States or of this state.

21 (5) The use of topical pharmaceutical agents for the purpose of
22 the examination of the human eye or eyes for any disease or
23 pathological condition.

24 (b) (1) An optometrist who is certified to use therapeutic
25 pharmaceutical agents, pursuant to Section 3041.3, may also
26 diagnose and treat the human eye or eyes, or any of its or their
27 appendages, for all of the following conditions:

28 (A) Through medical treatment, infections of the anterior
29 segment and adnexa, excluding the lacrimal gland, the lacrimal
30 drainage system, and the sclera in patients under 12 years of age.

31 (B) Ocular allergies of the anterior segment and adnexa.

32 (C) Ocular inflammation, nonsurgical in cause except when
33 comanaged with the treating physician and surgeon, limited to
34 inflammation resulting from traumatic iritis, peripheral corneal
35 inflammatory keratitis, episcleritis, and unilateral nonrecurrent
36 nongranulomatous idiopathic iritis in patients over 18 years of age.

37 (D) Traumatic or recurrent conjunctival or corneal abrasions
38 and erosions.

39 (E) ~~Corneal surface disease and dry eye disease. Nonmalignant~~
40 *ocular surface disease and dry eye disease.*

1 (F) Ocular pain, nonsurgical in cause except when comanaged
2 with the treating physician and surgeon, associated with conditions
3 optometrists are authorized to treat.

4 (G) Hypotrichosis and blepharitis.

5 (H) Pursuant to subdivision (e), glaucoma in patients over 18
6 years of age, as described in subdivision (j).

7 (2) For purposes of this section, “treat” means the use of
8 therapeutic pharmaceutical agents, as described in subdivision (c),
9 and the procedures described in subdivision (d).

10 (c) In diagnosing and treating the conditions listed in subdivision
11 (b), an optometrist certified to use therapeutic pharmaceutical
12 agents pursuant to Section 3041.3 may use *or prescribe, including*
13 *for rational off-label purposes*, all of the following therapeutic
14 pharmaceutical agents:

15 (1) Topical pharmaceutical agents for the examination of the
16 human eye or eyes for any disease or pathological condition,
17 including, but not limited to, topical miotics.

18 (2) Topical lubricants.

19 (3) Antiallergy agents. In using topical steroid medication for
20 the treatment of ocular allergies, an optometrist shall consult with
21 an ophthalmologist if the patient’s condition worsens 21 days after
22 diagnosis.

23 (4) Topical and oral anti-inflammatories.

24 (5) Topical antibiotic agents.

25 (6) Topical hyperosmotics.

26 (7) Topical and oral antiglaucoma agents pursuant to the
27 certification process defined in subdivision (e).

28 (8) Nonprescription medications used for the rational treatment
29 of an ocular disorder.

30 (9) Oral antihistamines.

31 (10) Prescription oral nonsteroidal anti-inflammatory agents.

32 (11) Oral antibiotics for medical treatment of ocular disease.

33 (12) Topical and oral antiviral medication for the medical
34 treatment of herpes simplex viral keratitis, herpes simplex viral
35 conjunctivitis, periocular herpes simplex viral dermatitis, varicella
36 zoster viral keratitis, varicella zoster viral conjunctivitis, and
37 periocular varicella zoster viral dermatitis.

38 (13) Oral analgesics that are not controlled substances.

39 (14) Codeine with ~~compounds and compounds~~, hydrocodone
40 with ~~compounds compound~~, and tramadol as listed in the California

Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use of these agents shall be limited to three days, with a referral to an ophthalmologist if the pain persists.

(15) Additional therapeutic pharmaceutical agents pursuant to subdivision (f).

(d) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may also perform all of the following procedures:

- (1) Corneal scraping with cultures.
- (2) Debridement of corneal epithelia.
- (3) Mechanical epilation.
- (4) Collection of blood by skin puncture or venipuncture for testing patients suspected of having diabetes.
- (5) Suture removal, with prior consultation with the treating physician and surgeon.
- (6) Treatment or removal of sebaceous cysts by expression.
- (7) Administration of oral fluorescein to patients suspected as having diabetic retinopathy.
- (8) Use of an auto-injector to counter anaphylaxis.
- (9) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, urinalysis, tear fluid analysis, and X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa. An optometrist may order other types of images subject to prior consultation with an ophthalmologist or appropriate physician and surgeon.
- (10) A clinical laboratory test or examination classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) (42 U.S.C. Sec. 263a; Public Law 100-578) and designated as waived in paragraph (9) necessary for the diagnosis of conditions and diseases of the eye or adnexa, or if otherwise specifically authorized by this chapter.
- (11) Skin testing to diagnose ocular allergies, limited to the superficial layer of the skin.
- (12) Punctal occlusion by plugs, excluding laser, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

1 (13) The *use or* prescription of *diagnostic or* therapeutic contact
2 lenses, including lenses or devices that incorporate a medication
3 or therapy the optometrist is certified to prescribe or provide.

4 (14) Removal of foreign bodies from the cornea, eyelid, and
5 conjunctiva with any appropriate instrument other than a scalpel.
6 Corneal foreign bodies shall be nonperforating, be no deeper than
7 the midstroma, and require no surgical repair upon removal.

8 (15) For patients over 12 years of age, lacrimal irrigation and
9 dilation, excluding probing of the nasal lacrimal tract. The board
10 shall certify any optometrist who graduated from an accredited
11 school of optometry before May 1, 2000, to perform this procedure
12 after submitting proof of satisfactory completion ~~and confirmation~~
13 of 10 procedures under the supervision of an ophthalmologist as
14 confirmed by the ophthalmologist. Any optometrist who graduated
15 from an accredited school of optometry on or after May 1, 2000,
16 shall be exempt from the certification requirement contained in
17 this paragraph.

18 (16) *Use of any topical or oral therapeutic pharmaceutical*
19 *agent or noninvasive medical device or technology authorized*
20 *pursuant to subdivision (f).*

21 (e) An optometrist certified pursuant to Section 3041.3 shall be
22 certified for the treatment of glaucoma, as described in subdivision
23 (j), in patients over 18 years of age after the optometrist meets the
24 following applicable requirements:

25 (1) For licensees who graduated from an accredited school of
26 optometry on or after May 1, 2008, submission of proof of
27 graduation from that institution.

28 (2) For licensees who were certified to treat glaucoma under
29 this section prior to January 1, 2009, submission of proof of
30 completion of that certification program.

31 (3) For licensees who completed a didactic course of not less
32 than 24 hours in the diagnosis, pharmacological, and other
33 treatment and management of glaucoma, submission of proof of
34 satisfactory completion of the case management requirements for
35 certification established by the board.

36 (4) For licensees who graduated from an accredited school of
37 optometry on or before May 1, 2008, and who are not described
38 in paragraph (2) or (3), submission of proof of satisfactory
39 completion of the requirements for certification established by the
40 board.

1 (f) (1) Any topical or oral therapeutic pharmaceutical agent,
2 which is not a controlled substance, or noninvasive medical device
3 or technology whose use does not constitute surgery, as defined
4 in subdivision (i), that is not expressly authorized for use or
5 prescription by an optometrist certified to use therapeutic
6 pharmaceutical agents pursuant to Section 3041.3 shall be deemed
7 to be authorized if it has received a United States Food and Drug
8 Administration approved indication for the diagnosis or treatment
9 of a condition authorized by this chapter. A licensee shall
10 successfully complete any clinical training imposed by a related
11 manufacturer prior to using any of those therapeutic
12 pharmaceutical agents or noninvasive medical devices or
13 technologies.

14 (2) Any other topical or oral therapeutic pharmaceutical agent,
15 which is not a controlled substance, or noninvasive medical device
16 or technology whose use does not constitute surgery, as defined
17 in subdivision (i), that is not expressly authorized for use or
18 prescription by an optometrist certified to use therapeutic
19 pharmaceutical agents pursuant to Section 3041.3 and does not
20 meet the requirements in paragraph (1) shall be deemed authorized
21 if approved by the board through regulation for the rational
22 treatment of a condition authorized by this chapter. Any regulation
23 under this paragraph shall require a licensee to successfully
24 complete an appropriate amount of clinical training to qualify to
25 use each topical or oral therapeutic pharmaceutical agent or
26 noninvasive medical device or technology approved by the board
27 pursuant to this paragraph.

28 (3) The subdivision shall not be construed to authorize either
29 of the following:

30 (A) Injections administered for cosmetic effect.

31 (B) The performance of blepharoplasty or other cosmetic
32 surgery procedure that reshapes the normal structures of the body
33 in order to improve appearance and self-esteem.

34 (~~F~~)

35 (g) (1) An optometrist certified pursuant to Section 3014.3 shall
36 be certified for the administration of immunizations after the
37 optometrist meets all of the following requirements:

38 (A) Completes an immunization training program endorsed by
39 the federal Centers for Disease Control and Prevention (CDC)
40 that, at a minimum, includes hands-on injection technique, clinical

1 evaluation of indications and contraindications of vaccines, and the
2 recognition and treatment of emergency reactions to vaccines, and
3 maintains that training.

4 (B) Is certified in basic life support.

5 (C) Complies with all state and federal recordkeeping and
6 reporting requirements, including providing documentation to the
7 patient's primary care provider and entering information in the
8 appropriate immunization registry designated by the immunization
9 branch of the State Department of Public Health.

10 (D) *Applies for an immunization certificate on a board-approved*
11 *form.*

12 (2) For the purposes of this section, "immunization" means the
13 administration of immunizations for influenza, herpes zoster virus,
14 and pneumococcus in compliance with individual Advisory
15 Committee on Immunization Practices (ACIP) vaccine
16 recommendations published by the CDC for persons 18 years of
17 age or older.

18 ~~(g)~~

19 (h) Other than for prescription ophthalmic devices described in
20 subdivision (b) of Section 2541, any dispensing of a therapeutic
21 pharmaceutical agent by an optometrist shall be without charge.

22 ~~(h)~~

23 (i) The practice of optometry does not include performing
24 surgery. "Surgery" means any procedure in which human tissue
25 is cut, altered, or otherwise infiltrated by mechanical or laser
26 means. "Surgery" does not include those procedures specified in
27 *paragraphs (1) to (15), inclusive, of* subdivision (d). This
28 subdivision does not limit an optometrist's authority to utilize
29 diagnostic laser and ultrasound technology within his or her scope
30 of practice.

31 ~~(i)~~

32 (j) An optometrist licensed under this chapter is subject to the
33 provisions of Section 2290.5 for purposes of practicing telehealth.

34 ~~(j)~~

35 (k) For purposes of this chapter, "glaucoma" means either of
36 the following:

37 (1) All primary open-angle glaucoma.

38 (2) Exfoliation and pigmentary glaucoma.

39 (3) (A) *Steroid induced glaucoma.*

1 (B) If an optometrist treats a patient for steroid induced
2 glaucoma the optometrist shall promptly notify the prescriber of
3 the steroid medication if the prescriber did not refer the patient
4 to the optometrist for treatment.

5 ~~(k)~~

6 (l) For purposes of this chapter, “adnexa” means ocular adnexa.

7 ~~(t)~~

8 (m) In an emergency, an optometrist shall stabilize, if possible,
9 and immediately refer any patient who has an acute attack of angle
10 closure to an ophthalmologist.

11 SEC. 3. Section 3041.1 of the Business and Professions Code
12 is amended to read:

13 3041.1. ~~Diagnosing~~ *An optometrist diagnosing or treating eye*
14 *disease shall be held to the same standard of care to which*
15 *physicians and surgeons and osteopathic physicians and surgeons*
16 *are held. An optometrist shall consult with and, if necessary, refer*
17 *to a physician and surgeon or other appropriate health care provider*
18 *when a situation or condition occurs that is beyond the*
19 *optometrists’s scope of practice. Consultations, referrals, and*
20 *notifications required by this section shall be documented in the*
21 *patient record.*

22 SEC. 4. Section 3041.2 of the Business and Professions Code
23 is amended to read:

24 3041.2. The State Board of Optometry shall, by regulation,
25 establish educational and examination requirements for licensure
26 to ensure the competence of optometrists to practice pursuant to
27 this chapter. Satisfactory completion of the educational and
28 examination requirements shall be a condition for the issuance of
29 an original optometrist license or certifications pursuant to this
30 chapter.

31 ~~SEC. 5. Section 3041.3 of the Business and Professions Code~~
32 ~~is amended to read:~~

33 ~~3041.3. (a) In order to be certified to use therapeutic~~
34 ~~pharmaceutical agents and authorized to diagnose and treat the~~
35 ~~conditions listed in subdivisions (b) and (d) of Section 3041, an~~
36 ~~optometrist shall apply for a certificate from the board and meet~~
37 ~~all requirements imposed by the board.~~

38 ~~(b) The board shall grant a certificate to use therapeutic~~
39 ~~pharmaceutical agents to any applicant who graduated from a~~
40 ~~California accredited school of optometry prior to January 1, 1996,~~

1 is licensed as an optometrist in California, and meets all of the
2 following requirements:

3 (1) Satisfactorily completes a didactic course of no less than 80
4 classroom hours in the diagnosis, pharmacological, and other
5 treatment and management of ocular disease provided by either
6 an accredited school of optometry in California or a accredited
7 ophthalmology residency program in California.

8 (2) Completes a preceptorship of no less than 65 hours, during
9 a period of not less than two months nor more than one year, in
10 either an ophthalmologist's office or an optometric clinic. The
11 training received during the preceptorship shall be on the diagnosis,
12 treatment, and management of ocular and systemic disease. The
13 preceptor shall certify completion of the preceptorship using a
14 form approved by the board. Authorization for the ophthalmologist
15 to serve as a preceptor shall be granted by an accredited school of
16 optometry in California. A preceptor shall be a board-certified
17 ophthalmologist in California licensed by and in good standing
18 with the Medical Board of California. This paragraph shall not be
19 construed to limit the total number of optometrist applicants for
20 whom an individual may serve as a preceptor, and is intended only
21 to ensure the quality of the preceptorship by requiring that the
22 ophthalmologist preceptor schedule the training so that each
23 applicant optometrist completes each of the 65 hours of the
24 preceptorship while scheduled with no more than two other
25 optometrist applicants.

26 (3) Successfully completes a minimum of 20 hours of
27 self-directed education.

28 (4) Passes the National Board of Examiners in Optometry's
29 "Treatment and Management of Ocular Disease" examination or,
30 in the event this examination is no longer offered, its equivalent,
31 as determined by the State Board of Optometry.

32 (5) Passes the examination issued upon completion of the
33 80-hour didactic course required under paragraph (1) and provided
34 by the accredited school of optometry or residency program in
35 ophthalmology.

36 (6) When any or all requirements contained in paragraph (1),
37 (4), or (5) have been satisfied on or after July 1, 1992, and before
38 January 1, 1996, an optometrist shall not be required to fulfill the
39 requirements to obtain certification to use therapeutic
40 pharmaceutical agents. In order for this paragraph to apply to the

1 requirement contained in paragraph (5), the didactic examination
2 that the applicant successfully completed shall meet equivalency
3 standards, as determined by the board.

4 (7) Any optometrist who graduated from an accredited school
5 of optometry on or after January 1, 1992, and before January 1,
6 1996, shall not be required to fulfill the requirements contained in
7 paragraphs (1), (4), and (5).

8 (e) The board shall grant a certificate to use therapeutic
9 pharmaceutical agents to any applicant who graduated from a
10 California accredited school of optometry on or after January 1,
11 1996, who is licensed as an optometrist in California, and who
12 meets all of the following requirements:

13 (1) Passes the National Board of Examiners in Optometry's
14 national board examination, or its equivalent, as determined by
15 the board.

16 (2) Of the total clinical training required by a school of
17 optometry's curriculum, successfully completed at least 65 of those
18 hours on the diagnosis, treatment, and management of ocular and
19 systemic disease.

20 (3) Is certified by an accredited school of optometry as
21 competent in the diagnosis, treatment, and management of ocular
22 and systemic disease to the extent authorized by this section.

23 (4) Is certified by an accredited school of optometry as having
24 completed at least 10 hours of experience with a board-certified
25 ophthalmologist.

26 (d) The board shall grant a certificate to use therapeutic
27 pharmaceutical agents to any applicant who is an optometrist who
28 obtained his or her license outside of California if he or she meets
29 all of the requirements for an optometrist licensed in California to
30 be certified to use therapeutic pharmaceutical agents.

31 (1) In order to obtain a certificate to use therapeutic
32 pharmaceutical agents, any optometrist who obtained his or her
33 license outside of California and graduated from an accredited
34 school of optometry prior to January 1, 1996, shall be required to
35 fulfill the requirements set forth in subdivision (b). In order for
36 the applicant to be eligible for the certificate to use therapeutic
37 pharmaceutical agents, the education he or she received at the
38 accredited out-of-state school of optometry shall be equivalent to
39 the education provided by any accredited school of optometry in
40 California for persons who graduated before January 1, 1996. For

1 those out-of-state applicants who request that any of the
2 requirements contained in subdivision (b) be waived based on
3 fulfillment of the requirement in another state, if the board
4 determines that the completed requirement was equivalent to that
5 required in California, the requirement shall be waived.

6 (2) In order to obtain a certificate to use therapeutic
7 pharmaceutical agents, any optometrist who obtained his or her
8 license outside of California and who graduated from an accredited
9 school of optometry on or after January 1, 1996, shall be required
10 to fulfill the requirements set forth in subdivision (c). In order for
11 the applicant to be eligible for the certificate to use therapeutic
12 pharmaceutical agents, the education he or she received by the
13 accredited out-of-state school of optometry shall be equivalent to
14 the education provided by any accredited school of optometry for
15 persons who graduate on or after January 1, 1996. For those
16 out-of-state applicants who request that any of the requirements
17 contained in subdivision (c) be waived based on fulfillment of the
18 requirement in another state, if the board determines that the
19 completed requirement was equivalent to that required in
20 California, the requirement shall be waived.

21 (3) The State Board of Optometry shall decide all issues relating
22 to the equivalency of an optometrist's education or training under
23 this subdivision.

24 SEC. 5. Section 3041.3 of the Business and Professions Code
25 is amended to read:

26 3041.3. (a) In order to be certified to use therapeutic
27 pharmaceutical agents and authorized to diagnose and treat the
28 conditions listed in subdivisions (b) and (e) (d) of Section 3041,
29 an optometrist shall apply for a certificate from the board and meet
30 all requirements imposed by the board.

31 (b) The board shall grant a therapeutic pharmaceutical agents
32 (TPA) certification to any applicant who graduated from a
33 California accredited school of optometry prior to January 1, 1996,
34 is licensed as an optometrist in California, and meets all of the
35 following requirements:

36 (1) Completes a preceptorship of no less than 65 hours, during
37 a period of not less than two months nor more than one year, with
38 either a TPA-certified optometrist in good standing or a physician
39 and surgeon board-certified in ophthalmology in good standing.
40 The training received during the preceptorship shall be on the

1 diagnosis, treatment, and management of ocular and systemic
2 disease. The preceptor shall certify completion of the preceptorship
3 using a form approved by the board. The individual serving as the
4 preceptor shall schedule no more than three optometrist applicants
5 for each of the required 65 hours of the preceptorship program.
6 This paragraph shall not be construed to limit the total number of
7 optometrist applicants for whom an individual may serve as a
8 preceptor, and is intended only to ensure the quality of the
9 preceptorship by requiring that the preceptor schedule the training
10 so that each applicant optometrist completes each of the 65 hours
11 of the preceptorship while scheduled with no more than two other
12 optometrist applicants.

13 (2) Successfully completes a minimum of 100 hours of directed
14 and accredited education in ocular and systemic diseases within
15 two years prior to meeting the requirements of paragraph (1).

16 (3) Passes the National Board of Examiners in Optometry's
17 "Treatment and Management of Ocular Disease" examination or,
18 in the event this examination is no longer offered, its equivalent,
19 as determined by the State Board of Optometry.

20 (c) The board shall grant a therapeutic pharmaceutical agents
21 certification to any applicant who graduated from a California
22 accredited school of optometry on or after January 1, 1996, who
23 is licensed as an optometrist in California, and who passes all
24 sections of the National Board of Examiners in Optometry's
25 national board examination or its equivalent, as determined by the
26 State Board of Optometry.

27 (d) The board shall grant a therapeutic pharmaceutical agents
28 certification to any applicant who is an optometrist who obtained
29 his or her license outside of California if he or she meets all of the
30 requirements for an optometrist licensed in California to be granted
31 a therapeutic pharmaceutical agents certification.

32 (1) In order to obtain a therapeutic pharmaceutical agents
33 certification, any optometrist who obtained his or her license
34 outside of California and graduated from an accredited school of
35 optometry prior to January 1, 1996, shall be required to fulfill the
36 requirements set forth in subdivision (b). In order for the applicant
37 to be eligible for therapeutic pharmaceutical agents certification,
38 the education he or she received at the accredited out-of-state
39 school of optometry shall be equivalent to the education provided
40 by any accredited school of optometry in California for persons

1 who graduate before January 1, 1996. For those out-of-state
2 applicants who request that any of the requirements contained in
3 subdivision (b) be waived based on fulfillment of the requirement
4 in another state, if the board determines that the completed
5 requirement was equivalent to that required in California, the
6 requirement shall be waived.

7 (2) In order to obtain a therapeutic pharmaceutical agents
8 certification, any optometrist who obtained his or her license
9 outside of California and who graduated from an accredited school
10 of optometry on or after January 1, 1996, shall be required to fulfill
11 the requirements set forth in subdivision (c). In order for the
12 applicant to be eligible for therapeutic pharmaceutical agents
13 certification, the education he or she received by the accredited
14 out-of-state school of optometry shall be equivalent to the
15 education provided by any accredited school of optometry for
16 persons who graduate on or after January 1, 1996. For those
17 out-of-state applicants who request that any of the requirements
18 contained in subdivision (c) be waived based on fulfillment of the
19 requirement in another state, if the board determines that the
20 completed requirement was equivalent to that required in
21 California, the requirement shall be waived.

22 (3) The State Board of Optometry shall decide all issues relating
23 to the equivalency of an optometrist's education or training under
24 this subdivision.

25 SEC. 6. Section 3056 of the Business and Professions Code is
26 amended to read:

27 3056. (a) The board may issue a license to practice optometry
28 to a person who meets all of the following qualifications:

29 (1) Has a degree as a doctor of optometry issued by an accredited
30 school or college of optometry.

31 (2) Is currently licensed in another state.

32 (3) Is currently a full-time faculty member of an accredited
33 California school or college of optometry and has served in that
34 capacity for a period of at least five continuous years.

35 (4) Has attained, at an accredited California school or college
36 of optometry, the academic rank of professor, associate professor,
37 or clinical professor, except that the status of adjunct or affiliated
38 faculty member shall not be deemed sufficient.

39 (5) Has successfully passed the board's jurisprudence
40 examination.

1 (6) Is in good standing, with no past or pending malpractice
2 awards or judicial or administrative actions.

3 (7) Has met the minimum continuing education requirements
4 set forth in Section 3059 for the current and preceding year.

5 (8) Has met the requirements of Section 3041.3 regarding the
6 use of therapeutic pharmaceutical agents under subdivision (d) of
7 Section 3041.

8 (9) Has never had his or her license to practice optometry
9 revoked or suspended.

10 (10) (A) Is not subject to denial based on any of the grounds
11 listed in Section 480.

12 (B) Is not currently required to register as a sex offender
13 pursuant to Section 290 of the Penal Code.

14 (11) Pays an application fee in an amount equal to the
15 application fee prescribed by the board pursuant to Section 3152.

16 (12) Files an application on a form prescribed by the board.

17 (b) Any license issued pursuant to this section shall expire as
18 provided in Section 3146, and may be renewed as provided in this
19 chapter, subject to the same conditions as other licenses issued
20 under this chapter.

21 (c) The term “in good standing,” as used in this section, means
22 that a person under this section:

23 (1) Is not currently under investigation nor has been charged
24 with an offense for any act substantially related to the practice of
25 optometry by any public agency, nor entered into any consent
26 agreement or subject to an administrative decision that contains
27 conditions placed by an agency upon a person’s professional
28 conduct or practice, including any voluntary surrender of license,
29 nor been the subject of an adverse judgment resulting from the
30 practice of optometry that the board determines constitutes
31 evidence of a pattern of incompetence or negligence.

32 (2) Has no physical or mental impairment related to drugs or
33 alcohol, and has not been found mentally incompetent by a
34 physician so that the person is unable to undertake the practice of
35 optometry in a manner consistent with the safety of a patient or
36 the public.

37 SEC. 7. Section 3057 of the Business and Professions Code is
38 amended to read:

39 3057. (a) The board may issue a license to practice optometry
40 to a person who meets all of the following requirements:

- 1 (1) Has a degree as a doctor of optometry issued by an accredited
2 school or college of optometry.
- 3 (2) Has successfully passed the licensing examination for an
4 optometric license in another state.
- 5 (3) Submits proof that he or she is licensed in good standing as
6 of the date of application in every state where he or she holds a
7 license, including compliance with continuing education
8 requirements.
- 9 (4) Is not subject to disciplinary action as set forth in subdivision
10 (h) of Section 3110. If the person has been subject to disciplinary
11 action, the board shall review that action to determine if it presents
12 sufficient evidence of a violation of this chapter to warrant the
13 submission of additional information from the person or the denial
14 of the application for licensure.
- 15 (5) Has furnished a signed release allowing the disclosure of
16 information from the National Practitioner Database and, if
17 applicable, the verification of registration status with the federal
18 Drug Enforcement Administration. The board shall review this
19 information to determine if it presents sufficient evidence of a
20 violation of this chapter to warrant the submission of additional
21 information from the person or the denial of the application for
22 licensure.
- 23 (6) Has never had his or her license to practice optometry
24 revoked or suspended in any state where the person holds a license.
- 25 (7) (A) Is not subject to denial of an application for licensure
26 based on any of the grounds listed in Section 480.
- 27 (B) Is not currently required to register as a sex offender
28 pursuant to Section 290 of the Penal Code.
- 29 (8) Has met the minimum continuing education requirements
30 set forth in Section 3059 for the current and preceding year.
- 31 (9) Has met the certification requirements of Section 3041.3 to
32 use therapeutic pharmaceutical agents under subdivision (d) of
33 Section 3041.
- 34 (10) Submits any other information as specified by the board
35 to the extent it is required for licensure by examination under this
36 chapter.
- 37 (11) Files an application on a form prescribed by the board,
38 with an acknowledgment by the person executed under penalty of
39 perjury and automatic forfeiture of license, of the following:

1 (A) That the information provided by the person to the board
2 is true and correct, to the best of his or her knowledge and belief.

3 (B) That the person has not been convicted of an offense
4 involving conduct that would violate Section 810.

5 (12) Pays an application fee in an amount equal to the
6 application fee prescribed pursuant to subdivision (a) of Section
7 3152.

8 (13) Has successfully passed the board's jurisprudence
9 examination.

10 (b) If the board finds that the competency of a candidate for
11 licensure pursuant to this section is in question, the board may
12 require the passage of a written, practical, or clinical examination
13 or completion of additional continuing education or coursework.

14 (c) In cases where the person establishes, to the board's
15 satisfaction, that he or she has been displaced by a federally
16 declared emergency and cannot relocate to his or her state of
17 practice within a reasonable time without economic hardship, the
18 board may reduce or waive the fees required by paragraph (12) of
19 subdivision (a).

20 (d) Any license issued pursuant to this section shall expire as
21 provided in Section 3146, and may be renewed as provided in this
22 chapter, subject to the same conditions as other licenses issued
23 under this chapter.

24 (e) The term "in good standing," as used in this section, means
25 that a person under this section:

26 (1) Is not currently under investigation nor has been charged
27 with an offense for any act substantially related to the practice of
28 optometry by any public agency, nor entered into any consent
29 agreement or subject to an administrative decision that contains
30 conditions placed by an agency upon a person's professional
31 conduct or practice, including any voluntary surrender of license,
32 nor been the subject of an adverse judgment resulting from the
33 practice of optometry that the board determines constitutes
34 evidence of a pattern of incompetence or negligence.

35 (2) Has no physical or mental impairment related to drugs or
36 alcohol, and has not been found mentally incompetent by a licensed
37 psychologist or licensed psychiatrist so that the person is unable
38 to undertake the practice of optometry in a manner consistent with
39 the safety of a patient or the public.

1 SEC. 8. Section 3110 of the Business and Professions Code is
2 amended to read:

3 3110. The board may take action against any licensee who is
4 charged with unprofessional conduct, and may deny an application
5 for a license if the applicant has committed unprofessional conduct.
6 In addition to other provisions of this article, unprofessional
7 conduct includes, but is not limited to, the following:

8 (a) Violating or attempting to violate, directly or indirectly
9 assisting in or abetting the violation of, or conspiring to violate
10 any provision of this chapter or any of the rules and regulations
11 adopted by the board pursuant to this chapter.

12 (b) Gross negligence.

13 (c) Repeated negligent acts. To be repeated, there must be two
14 or more negligent acts or omissions.

15 (d) Incompetence.

16 (e) The commission of fraud, misrepresentation, or any act
17 involving dishonesty or corruption, that is substantially related to
18 the qualifications, functions, or duties of an optometrist.

19 (f) Any action or conduct that would have warranted the denial
20 of a license.

21 (g) The use of advertising relating to optometry that violates
22 Section 651 or 17500.

23 (h) Denial of licensure, revocation, suspension, restriction, or
24 any other disciplinary action against a health care professional
25 license by another state or territory of the United States, by any
26 other governmental agency, or by another California health care
27 professional licensing board. A certified copy of the decision or
28 judgment shall be conclusive evidence of that action.

29 (i) Procuring his or her license by fraud, misrepresentation, or
30 mistake.

31 (j) Making or giving any false statement or information in
32 connection with the application for issuance of a license.

33 (k) Conviction of a felony or of any offense substantially related
34 to the qualifications, functions, and duties of an optometrist, in
35 which event the record of the conviction shall be conclusive
36 evidence thereof.

37 (l) Administering to himself or herself any controlled substance
38 or using any of the dangerous drugs specified in Section 4022, or
39 using alcoholic beverages to the extent, or in a manner, as to be
40 dangerous or injurious to the person applying for a license or

1 holding a license under this chapter, or to any other person, or to
2 the public, or, to the extent that the use impairs the ability of the
3 person applying for or holding a license to conduct with safety to
4 the public the practice authorized by the license, or the conviction
5 of a misdemeanor or felony involving the use, consumption, or
6 self-administration of any of the substances referred to in this
7 subdivision, or any combination thereof.

8 (m) (1) Committing or soliciting an act punishable as a sexually
9 related crime, if that act or solicitation is substantially related to
10 the qualifications, functions, or duties of an optometrist.

11 (2) Committing any act of sexual abuse, misconduct, or relations
12 with a patient. The commission of and conviction for any act of
13 sexual abuse, sexual misconduct, or attempted sexual misconduct,
14 whether or not with a patient, shall be considered a crime
15 substantially related to the qualifications, functions, or duties of a
16 licensee. This paragraph shall not apply to sexual contact between
17 any person licensed under this chapter and his or her spouse or
18 person in an equivalent domestic relationship when that licensee
19 provides optometry treatment to his or her spouse or person in an
20 equivalent domestic relationship.

21 (3) Conviction of a crime that requires the person to register as
22 a sex offender pursuant to Chapter 5.5 (commencing with Section
23 290) of Title 9 of Part 1 of the Penal Code. A conviction within
24 the meaning of this paragraph means a plea or verdict of guilty or
25 a conviction following a plea of nolo contendere. A conviction
26 described in this paragraph shall be considered a crime substantially
27 related to the qualifications, functions, or duties of a licensee.

28 (n) Repeated acts of excessive prescribing, furnishing, or
29 administering of controlled substances or dangerous drugs specified
30 in Section 4022, or repeated acts of excessive treatment.

31 (o) Repeated acts of excessive use of diagnostic or therapeutic
32 procedures, or repeated acts of excessive use of diagnostic or
33 treatment facilities.

34 (p) The prescribing, furnishing, or administering of controlled
35 substances or drugs specified in Section 4022, or treatment without
36 a good faith prior examination of the patient and optometric reason.

37 (q) The failure to maintain adequate and accurate records
38 relating to the provision of services to his or her patients.

1 (r) Performing, or holding oneself out as being able to perform,
2 or offering to perform, any professional services beyond the scope
3 of the license authorized by this chapter.

4 (s) The practice of optometry without a valid, unrevoked,
5 unexpired license.

6 (t) The employing, directly or indirectly, of any suspended or
7 unlicensed optometrist to perform any work for which an optometry
8 license is required.

9 (u) Permitting another person to use the licensee's optometry
10 license for any purpose.

11 (v) Altering with fraudulent intent a license issued by the board,
12 or using a fraudulently altered license, permit certification or any
13 registration issued by the board.

14 (w) Except for good cause, the knowing failure to protect
15 patients by failing to follow infection control guidelines of the
16 board, thereby risking transmission of bloodborne infectious
17 diseases from optometrist to patient, from patient to patient, or
18 from patient to optometrist. In administering this subdivision, the
19 board shall consider the standards, regulations, and guidelines of
20 the State Department of Public Health developed pursuant to
21 Section 1250.11 of the Health and Safety Code and the standards,
22 guidelines, and regulations pursuant to the California Occupational
23 Safety and Health Act of 1973 (Part 1 (commencing with Section
24 6300) of Division 5 of the Labor Code) for preventing the
25 transmission of HIV, hepatitis B, and other bloodborne pathogens
26 in health care settings. As necessary, the board may consult with
27 the Medical Board of California, the California Board of Podiatric
28 Medicine, the Board of Registered Nursing, and the Board of
29 Vocational Nursing and Psychiatric Technicians of the State of
30 California, to encourage appropriate consistency in the
31 implementation of this subdivision.

32 (x) Failure or refusal to comply with a request for the clinical
33 records of a patient, that is accompanied by that patient's written
34 authorization for release of records to the board, within 15 days
35 of receiving the request and authorization, unless the licensee is
36 unable to provide the documents within this time period for good
37 cause.

38 (y) Failure to refer a patient to an appropriate physician and
39 surgeon if an examination of the eyes indicates a substantial

1 likelihood of any pathology that requires the attention of that
2 physician and surgeon.

3 SEC. 9. Section 3152 of the Business and Professions Code is
4 amended to read:

5 3152. The amounts of fees and penalties prescribed by this
6 chapter shall be established by the board in amounts not greater
7 than those specified in the following schedule:

8 (a) The fee for applicants applying for a license shall not exceed
9 two hundred seventy-five dollars (\$275).

10 (b) The fee for renewal of an optometric license shall not exceed
11 five hundred dollars (\$500).

12 (c) The annual fee for the renewal of a branch office license
13 shall not exceed seventy-five dollars (\$75).

14 (d) The fee for a branch office license shall not exceed
15 seventy-five dollars (\$75).

16 (e) The penalty for failure to pay the annual fee for renewal of
17 a branch office license shall not exceed twenty-five dollars (\$25).

18 (f) The fee for issuance of a license or upon change of name
19 authorized by law of a person holding a license under this chapter
20 shall not exceed twenty-five dollars (\$25).

21 (g) The delinquency fee for renewal of an optometric license
22 shall not exceed fifty dollars (\$50).

23 (h) The application fee for a certificate to perform lacrimal
24 irrigation and dilation shall not exceed fifty dollars (\$50).

25 (i) The application fee for a certificate to treat glaucoma shall
26 not exceed fifty dollars (\$50).

27 (j) The fee for approval of a continuing education course shall
28 not exceed one hundred dollars (\$100).

29 (k) The fee for issuance of a statement of licensure shall not
30 exceed forty dollars (\$40).

31 (l) The fee for biennial renewal of a statement of licensure shall
32 not exceed forty dollars (\$40).

33 (m) The delinquency fee for renewal of a statement of licensure
34 shall not exceed twenty dollars (\$20).

35 (n) The application fee for a fictitious name permit shall not
36 exceed fifty dollars (\$50).

37 (o) The renewal fee for a fictitious name permit shall not exceed
38 fifty dollars (\$50).

39 (p) The delinquency fee for renewal of a fictitious name permit
40 shall not exceed twenty-five dollars (\$25).

1 (q) The fee for a retired license shall not exceed twenty-five
2 dollars (\$25).

3 (r) The fee for a retired license with volunteer designation shall
4 not exceed fifty dollars (\$50).

5 (s) The biennial renewal fee for a retired license with volunteer
6 designation shall not exceed fifty dollars (\$50).

7 (t) The application fee for a certificate to administer
8 immunizations shall not exceed fifty dollars (\$50).

9 SEC. 10. No reimbursement is required by this act pursuant to
10 Section 6 of Article XIII B of the California Constitution because
11 the only costs that may be incurred by a local agency or school
12 district will be incurred because this act creates a new crime or
13 infraction, eliminates a crime or infraction, or changes the penalty
14 for a crime or infraction, within the meaning of Section 17556 of
15 the Government Code, or changes the definition of a crime within
16 the meaning of Section 6 of Article XIII B of the California
17 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 505
Author: Caballero
Bill Date: March 27, 2017, Amended
Subject: Physicians and Surgeons: Probation
Sponsor: California Medical Association
Position: Oppose

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit the Medical Board of California (Board) from entering into a stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes specified charges.

BACKGROUND:

The Board uses its Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (16 CCR section 1361) and the Uniform Standards for Substance-Abusing Licensees (Uniform Standards) (16 CCR section 1361.5) as the framework for determining the appropriate penalty for charges filed against a physician. Business and Professions (B&P) Code section 2229 identifies that protection of the public shall be the highest priority for the Board, but also requires that wherever possible, the actions should be calculated to aid in the rehabilitation of the licensee. While the Disciplinary Guidelines and Uniform Standards frame the recommended penalty, the facts of each individual case may support a deviation from the guidelines. After the filing of an accusation and/or petition to revoke probation, a respondent physician must file a notice of defense within 15 days indicating they intend to present a defense to the accusation and/or petition to revoke probation or that they are interested in a settlement agreement. If the individual requests a hearing, existing law (Government Code sections 11511.5 and 11511.7) requires that a prehearing conference be held to explore settlement possibilities and prepare stipulations, as well as schedule a mandatory settlement conference, in an attempt to resolve the case through a stipulated settlement before proceeding to the administrative hearing.

The assigned deputy attorney general (DAG) reviews the case, any mitigation provided, the strengths and weaknesses of the case, the Board's Disciplinary Guidelines, and, when applicable, any prior disciplinary action against the respondent physician, and drafts a settlement recommendation that frames the recommended penalty. In addition, this settlement recommendation takes into account consumer protection and B&P Code section 2229(b). The DAG's recommendation is then reviewed and either approved or edited by the supervising DAG. Once that approval is received, the DAG submits the settlement recommendation to the Board's Executive Director for review and consideration.

The Board's Executive Director reviews the settlement recommendation using the same criteria as the DAG and either approves or changes the settlement recommendation. The

DAG then negotiates with the respondent physician and/or their counsel to settle the case with the recommended penalty. Both the prehearing settlement conference and the mandatory settlement conference have the assistance of an administrative law judge (ALJ). This ALJ reviews the case and hears information from the DAG and the respondent physician and/or their counsel and then assists in negotiating the settlement. During the settlement conference, the Board representative must be available to authorize any change to the previously agreed settlement recommendation.

If a settlement agreement is reached, the stipulated settlement document must be approved by a panel of the Board, unless the settlement is for a stipulated surrender. The Board then has the ability to adopt the settlement as written, request changes to the settlement, or request the matter go to hearing. In the process to settle a case, public protection is the first priority, and must be weighed with rehabilitation of the physician. When making a decision on a stipulation, the panel members are provided the strengths and weaknesses of the case, and weigh all factors.

ANALYSIS

This bill would prohibit the Board from entering into a stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes any of the following:

- Felony conviction involving harm to patient safety or health.
- Drug or alcohol abuse directly resulting in harm to patient safety or health.
- Sexual act or sexual exploitation as defined in Section 726 and subdivision (a) of Section 729.

Any settlement recommendation stipulated to by the Board must provide an appropriate level of public protection and rehabilitation. Settling cases by stipulations that are agreed to by both sides facilitates consumer protection by rehabilitating the physician in a more expeditious manner. By entering into a stipulation, it puts the individual on probation or restriction sooner and the public is able to see the action taken by the Board more timely than if the matter went to hearing. In addition, the Board may get more terms and conditions through the settlement process than would have been achieved if the matter went to hearing.

If the Board is required to go to hearing for certain cases, there will be a significant fiscal impact to the Board and it will also significantly increase the Board's enforcement timelines. This bill will not enhance consumer protection, as it will result in physicians practicing longer with no monitoring or restrictions by the Board. The Board's primary mission is consumer protection and this bill does not further that mission, as such, the Board opposes this bill.

FISCAL:

Using the categories specified in this bill and comparing them to the categories of discipline in the Board's 15/16 Annual Report, minus the number of proposed decisions in that same time frame with the same categories, Board staff estimates that 95 cases will not be allowed to settle and will have to go to hearing. It is important to note that the Board had to use all cases in those

categories, as the Board will not know beforehand which cases will have the disciplinary outcome of probation. In the probation notification bill from last year, Board staff estimated the cost of going to hearing at \$35,000 per case. With the estimated 95 cases, times the hearing cost, this would result in a cost of \$3,325,000 to the Board. It is possible that a fee increase may be needed if this bill were to be enacted. The Board would have to contract for a fee audit to confirm any possible fee increase.

SUPPORT:

California Medical Association (Sponsor)

OPPOSITION:

Medical Board of California

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 505

Introduced by Assembly Member Caballero

February 13, 2017

An act to add Section 2227.1 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST

AB 505, as amended, Caballero. Physicians and surgeons: probation.

Under existing law, a physician and surgeon whose matter has been heard by an administrative law judge, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the Medical Board of California, is authorized to be subject to, among other things, license revocation, suspension, or probation, as specified. Existing law authorizes the board to discipline a licensee by placing him or her on probation subject to specified conditions.

This bill would prohibit the board from entering into any stipulation for disciplinary action, ~~including placing~~ *action if the stipulation places* a licensee on ~~probation, if~~ *probation and* the operative accusation includes specified acts.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 2227.1 is added to the Business and
- 2 Professions Code, to read:

1 2227.1. Notwithstanding Sections 2227 and 2228, the board
2 may not enter into any stipulation for disciplinary ~~action, which~~
3 ~~includes placing~~ *action if the stipulation places* a licensee on
4 ~~probation, if probation and~~ the operative accusation includes any
5 of the following:
6 (a) Felony conviction involving harm to patient safety or health.
7 (b) Drug or alcohol abuse directly resulting in harm to patient
8 safety or health.
9 (c) Sexual act or sexual exploitation as defined in Section 726
10 and subdivision (a) of Section 729.

ASSEMBLY BILL

No. 706

Introduced by Assembly Member Patterson

February 15, 2017

An act to amend Section 2423 of, and to repeal Section 2422 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 706, as introduced, Patterson. Medical Board of California: licenses.

Existing law provides for the licensure and regulation of specific health care professions by the Medical Board of California or a licensing and regulatory authority within the jurisdiction of that board. The Medical Practice Act determines the expiration of, and governs the renewal of, certificates, licenses, registrations, and permits issued by or under the Medical Board of California, including physician and surgeon's certificates, certificates to practice podiatric medicine, physical therapy licenses and approvals, registrations of research psychoanalysts, registrations of dispensing opticians, registrations of nonresident contact lens sellers, registrations of spectacle lens dispensers, registrations of contact lens dispensers, certificates to practice midwifery, and fictitious-name permits. Under the act, physician and surgeon's certificates, certificates to practice podiatric medicine, registrations of spectacle lens dispensers and contact lens dispensers, and certificates to practice midwifery expire on the last day of the birth month of the licensee during the 2nd year of a 2-year term. Under that act, registrations of dispensing opticians expire on the last day of the month in which the license was issued during the 2nd year of a 2-year term.

This bill would instead have all of the above licenses expire at the end, as provided, of a 2-year period from the date the license was issued.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2422 of the Business and Professions
2 Code is repealed.

3 ~~2422. All licenses expire and become invalid at 12 midnight~~
4 ~~on the last day of February of each even-numbered year if not~~
5 ~~renewed.~~

6 ~~To renew an unexpired license, a licensee shall, on or before the~~
7 ~~date it would otherwise expire, apply for renewal on a form~~
8 ~~prescribed by the licensing authority and pay the prescribed renewal~~
9 ~~fee.~~

10 SEC. 2. Section 2423 of the Business and Professions Code is
11 amended to read:

12 ~~2423. (a) Notwithstanding Section 2422: All physician and~~
13 ~~surgeon's certificates, certificates to practice podiatric medicine,~~
14 ~~registrations of dispensing opticians, spectacle lens dispensers,~~
15 ~~and contact lens dispensers, and certificates to practice midwifery~~
16 ~~shall expire at 12 midnight on the last day of the month in which~~
17 ~~the license was issued during the second year of a two-year term~~
18 ~~commencing from the date of issuance.~~

19 ~~(1) All physician and surgeon's certificates, certificates to~~
20 ~~practice podiatric medicine, registrations of spectacle lens~~
21 ~~dispensers and contact lens dispensers, and certificates to practice~~
22 ~~midwifery shall expire at 12 midnight on the last day of the birth~~
23 ~~month of the licensee during the second year of a two-year term~~
24 ~~if not renewed.~~

25 ~~(2) Registrations of dispensing opticians will expire at midnight~~
26 ~~on the last day of the month in which the license was issued during~~
27 ~~the second year of a two-year term if not renewed.~~

28 ~~(b) The Division of Licensing shall establish by regulation~~
29 ~~procedures for the administration of a birth date renewal program,~~
30 ~~including, but not limited to, the establishment of a system of~~
31 ~~staggered license expiration dates such that a relatively equal~~
32 ~~number of licenses expire monthly.~~

33 ~~(c)~~

1 (b) To renew an unexpired license, the ~~licensee shall~~, *licensee*,
2 on or before the ~~dates~~ *date* on which it would otherwise expire,
3 *shall* apply for renewal on a form prescribed by the licensing
4 authority and pay the prescribed renewal fee.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 715
Author: Wood
Bill Date: June 8, 2017, Amended
Subject: Workgroup Review of Opioid Pain Reliever Use and Abuse
Sponsor: Author
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the California Department of Public Health (CDPH) to convene a workgroup to review existing prescription guidelines and develop a recommended statewide guideline addressing best practices for prescribing opioids for instances of acute, short-term pain.

BACKGROUND:

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

The Medical Board of California (Board) developed a Prescribing Task Force that held multiple meetings to identify best practices, hear from speakers regarding this issue, and update the Board's Guidelines for Prescribing Controlled Substances for Pain. This task force had numerous meetings with interested parties and discussions with experts in the field of pain management to develop this document, which was adopted by the Board in November 2014. These Guidelines are intended to educate physicians on effective pain management in California by avoiding under treatment, overtreatment, or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. The Guidelines contain a significant amount of information and are supplemented with as many resources as practical via the appendices and links to websites that further assist a physician when prescribing controlled substances for pain. The Guidelines discuss several areas, including understanding pain, special patient populations, patient evaluation and risk stratification, consultation, treatment plan and objectives, patient consent, pain management agreements, counseling patient on overdose risk and response, initiating an opioid trial, ongoing patient assessment, and several other areas.

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop

collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

In 2016, the Centers for Disease Control (CDC) developed and published the CDC Guidelines for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. These Guidelines address clinical practices on determining when to initiate or continue opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use.

ANALYSIS

This bill makes findings and declarations regarding the epidemic of opioid abuse in the United States. This bill would require CDPH to convene a workgroup to do all of the following:

- Review existing prescription guidelines, including, but not limited to, guidelines developed by the CDC and the Board.
- Develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers for instances of acute, short-term pain. In developing the statewide guideline, the workgroup may consider, among other things, evidence-based, peer-reviewed research; lessons learned from demonstration pilot projects; the effectiveness of long-lasting, non-narcotic, local anesthetic alternatives for managing post-surgical acute pain; or other policies that have been successful in reducing opioid use and abuse. The guidelines shall include, but not be limited to, the appropriateness of limiting initial prescription duration and the appropriateness of a differing prescribing protocol for individuals under 21 years of age, and pregnant or lactating women.

This bill would require CDPH to determine the membership of the workgroup, ensuring an open and inclusive process. Members of the workgroup shall include, but not be limited to, family practitioners, emergency room physicians, osteopathic physicians,

dentists, surgeons, pain management experts, and experts in the field of substance abuse prevention and treatment.

This bill would require CDPH to submit a report to the Legislature, on or before March 1, 2019, which shall contain the workgroup's conclusions and required recommendations, and any other recommendations made by the workgroup. This bill would sunset the workgroup on January 1, 2020.

The author believes that while several multi-agency efforts are underway related to public education, safe storage, and treatment for opioid misuse, the response to the crisis has not been sufficiently aggressive in efforts to intervene and change existing prescribing practice related to the appropriateness of use and initial dosage of opioid prescriptions. Although there are numerous guidelines and recommendations for opioid prescribers, the author believes it is prudent to conduct an extensive review of these guidelines by healthcare professionals, experts in the fields of pain management and addiction, and other credible stakeholders to develop a single set of recommendations for practitioners to use in prescribing opioids.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. Although the Board has already drafted guidelines on this issue through a very extensive process that included stakeholder and expert input, a third party review of all existing guidelines may allow for additional input and updates for state guidelines. As such, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: American Cancer Society Cancer Action Network
California Access Coalition
California Council of Community Behavioral Health Agencies
California Health + Advocates
California State Sheriffs' Association
McKesson Corporation
Pacira Pharmaceuticals
Pharmaceutical Research and Manufacturers of California
(PhRMA)

OPPOSITION: CDPH

AMENDED IN SENATE JUNE 8, 2017

AMENDED IN ASSEMBLY APRIL 18, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 715

Introduced by Assembly Member Wood

February 15, 2017

An act to add and repeal Part 6.3 (commencing with Section 1179.90) of Division 1 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 715, as amended, Wood. Workgroup review of opioid pain reliever use and abuse.

Existing law creates the State Department of Public Health and vests it with duties, powers, functions, jurisdiction, and responsibilities with regard to the advancement of public health.

This bill would require the department to convene a workgroup, comprised of members selected by the department, to review existing prescription guidelines and develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers. The bill would require the department, on or before March 1, 2019, to report the workgroup's conclusions and recommendations to the Legislature. The bill would repeal its provisions on January 1, 2020.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Opioid abuse is a serious problem that affects the health, social, and economic welfare of the state.

(b) After alcohol, prescription drugs are the most commonly abused substances by Americans over 12 years of age.

(c) Almost 2 million people in the United States suffer from substance use disorders related to prescription opioid pain relievers.

(d) Deaths involving prescription opioid pain relievers represent the largest portion of drug overdose deaths involving heroin or cocaine.

(e) The number of unintentional overdose deaths involving prescription opioid pain relievers has more than quadrupled since 1999.

(f) The federal Centers for Disease Control and Prevention recommends that healthcare providers should only use opioid pain relievers in carefully screened and monitored patients when nonopioid treatments are insufficient to manage pain.

(g) Long-lasting, nonnarcotic, local anesthetic, and multimodal alternatives for managing postsurgical acute pain have reduced, and in some instances, eliminated the need for patient dependency on opioid pain relievers.

SEC. 2. Part 6.3 (commencing with Section 1179.90) is added to Division 1 of the Health and Safety Code, to read:

PART 6.3 WORKGROUP REVIEW OF OPIOID PAIN
RELIEVER USE AND ABUSE

1179.90. (a) The State Department of Public Health shall convene a workgroup to do all of the following:

(1) Review existing prescription guidelines, including, but not limited to, guidelines developed by the federal Centers for Disease Control and Prevention and the Medical Board of California.

(2) Develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers for instances of acute, short-term pain. In developing the statewide guideline, the workgroup may consider, among other things, evidence-based, peer-reviewed research, lessons learned from demonstration pilot

1 projects, *the effectiveness of long-lasting, nonnarcotic, local*
2 *anesthetic alternatives for managing postsurgical acute pain*, or
3 other policies that have been successful in reducing opioid use and
4 abuse. The guidelines shall include, but not be limited to, the
5 appropriateness of limiting initial prescription duration and the
6 appropriateness of a differing prescribing protocol for individuals
7 under 21 years of ~~age~~. *age, and pregnant or lactating women.*

8 (b) The State Department of Public Health shall determine the
9 membership of the workgroup, ensuring an open and inclusive
10 process. Members of the workgroup shall include, but not be
11 limited to, family practitioners, emergency room physicians,
12 *osteopathic physicians*, dentists, surgeons, pain management
13 experts, and experts in the field of substance abuse prevention and
14 treatment.

15 1179.91. On or before March 1, 2019, the State Department
16 of Public Health shall submit to the Legislature a report of the
17 workgroup's conclusions and recommendations pursuant to
18 paragraphs (1) and (2) of subdivision (a) of Section 1179.90 and
19 any other recommendations made by the workgroup. The report
20 shall be submitted in compliance with Section 9795 of the
21 Government Code.

22 1179.92. This part shall remain in effect only until January 1,
23 2020, and as of that date is repealed.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 845
Author: Wood
Bill Date: July 11, 2017, Amended
Subject: Cannabidiol
Sponsor: Epilepsy Foundation of Greater Los Angeles
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician, pharmacist, or other authorized healing arts licensee acting within his or her scope of practice, to prescribe, furnish, or dispense cannabidiol, if it is excluded from Schedule 1 of the federal Controlled Substances Act (Act) and placed on a schedule other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. If a physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses cannabidiol in accordance with federal law, they shall be deemed to be in compliance with state law. This bill is an urgency statute and will take effect immediately upon being signed into law.

BACKGROUND (taken from the fact sheet):

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into five designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I. Existing law places marijuana in Schedule I and cannabidiol is a compound found in marijuana.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. There is no “one size fits all” treatment option and about one million people live with uncontrolled or intractable seizures. Access to new treatment is particularly important for these individuals, who live with the continual risk of serious injuries and loss of life.

The FDA is currently reviewing at least one cannabidiol or CBD derived therapy (Epidiolex) that shows promise for the treatment of Dravet and Lennox Gastaut syndromes (LGS), tuberous sclerosis complex (TSC) and potentially other rare epilepsies. This potential treatment option has both Orphan Drug Designation from the FDA for Dravet syndrome and also Orphan Drug Designation for LGS and TSC, other rare types of epilepsy. Given the fast track designation, this potential treatment option could be available as soon as early 2018.

ANALYSIS

This bill would allow a physician, pharmacist, or other authorized healing arts licensee acting within his or her scope of practice, to prescribe, furnish, or dispense cannabidiol, if it is excluded from Schedule 1 of the federal Act and placed on a schedule other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. If a physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses cannabidiol in accordance with federal law, they shall be deemed to be in compliance with state law.

This bill would state that upon the effective date of one of the federal changes specified in this bill, notwithstanding any other state law, a product composed of cannabidiol may be prescribed, furnished, dispensed, transferred, possessed, or used in accordance with federal law and is authorized pursuant to state law. This bill is an urgency statute and will take effect immediately upon being signed into law.

Per the author's office, currently any product that contains any quantity of marijuana is considered a Schedule I controlled substance, unless specifically exempted. Under current law, should a product be derived from cannabidiol, it would still be considered a Schedule I controlled substance and therefore could not be prescribed in California. According to the author, the purpose of this bill is to ensure Californians with uncontrolled seizures will have continued access to FDA approved epilepsy treatments derived from cannabidiol.

This bill would ensure that if the federal government approves cannabidiol treatment, then cannabidiol can be prescribed, furnished and dispensed in California, in accordance with federal law. This bill merely aligns state law with federal law to allow treatments authorized by the federal government in the future. The Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: Epilepsy Foundation of Greater Los Angeles (Sponsor); California Life Sciences Association; Dravet Syndrome Foundation; Epilepsy Foundation of Northern California; LGS Foundation; Tuberous Sclerosis Alliance; and two individuals

OPPOSITION: None on file

AMENDED IN SENATE JULY 11, 2017

AMENDED IN SENATE JUNE 7, 2017

AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 845

Introduced by Assembly Member Wood

February 16, 2017

An act to add Section 11150.2 to the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 845, as amended, Wood. Cannabidiol.

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V. Existing law places ~~marijuana~~ *cannabis* in Schedule I. Cannabidiol is a compound found in ~~marijuana~~ *cannabis*.

Existing law restricts the prescription, furnishing, possession, sale, and use of controlled substances, including ~~marijuana~~ *cannabis* and synthetic cannabinoid compounds, and makes a violation of those laws a crime, except as specified.

This bill, if one of specified changes in federal law regarding the controlled substance cannabidiol occurs, would provide that a physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses a product composed of cannabidiol, in

accordance with federal law, is in compliance with state law governing those acts. The bill would also provide that upon the effective date of one of those changes in federal law regarding cannabidiol, the prescription, furnishing, dispensing, transfer, possession, or use of that product in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature finds and declares that both
2 children and adults with epilepsy are in desperate need of new
3 treatment options and that cannabidiol is showing potential as one
4 of these treatments. If federal laws prohibiting the prescription of
5 medications composed of cannabidiol are repealed or if an
6 exception from the general prohibition is enacted permitting the
7 prescription of drugs composed of cannabidiol, patients should
8 have rapid access to this treatment option. The availability of this
9 new prescription medication is intended to augment, not to restrict
10 or otherwise amend, other cannabinoid treatment modalities
11 currently available under state law.

12 SEC. 2. Section 11150.2 is added to the Health and Safety
13 Code, to read:

14 11150.2. (a) Notwithstanding any other law, if cannabidiol is
15 ~~removed~~ *excluded* from Schedule I of the federal Controlled
16 Substances Act and placed on a schedule of the act other than
17 Schedule I, or if a product composed of cannabidiol is approved
18 by the federal Food and Drug Administration and either placed on
19 a schedule of the act other than Schedule I, or exempted from one
20 or more provisions of the act, so as to permit a physician,
21 pharmacist, or other authorized healing arts licensee acting within
22 his or her scope of practice, to prescribe, furnish, or dispense that
23 product, the physician, pharmacist, or other authorized healing
24 arts licensee who prescribes, furnishes, or dispenses that product
25 in accordance with federal law shall be deemed to be in compliance
26 with state law governing those acts.

1 (b) For purposes of this chapter, upon the effective date of one
2 of the changes in federal law described in subdivision (a),
3 notwithstanding any other state law, a product composed of
4 cannabidiol may be prescribed, furnished, dispensed, transferred,
5 possessed, or used in accordance with federal law and is authorized
6 pursuant to state law.

7 SEC. 3. This act is an urgency statute necessary for the
8 immediate preservation of the public peace, health, or safety within
9 the meaning of Article IV of the California Constitution and shall
10 go into immediate effect. The facts constituting the necessity are:

11 In order to ensure that patients are able to obtain access to a new
12 treatment modality as soon as federal law makes it available, it is
13 necessary that this act take effect immediately.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1048
Author: Arambula
Bill Date: July 3, 2017, Amended
Subject: Health Care: Pain Management and Schedule II Drug Prescriptions
Sponsor: California Medical Association
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would, beginning July 1, 2018, authorize a pharmacist to dispense opioids as partial fills if requested by the prescriber or patient. This bill would also remove the requirement that pain be assessed at the same time as vital signs.

BACKGROUND:

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

Until 2016, federal law limited partially filling a Schedule II controlled substance to narrow circumstances. Section 702 of the Comprehensive Addiction and Recovery Act (CARA) expanded the allowable circumstances for a Schedule II partial fill.

AB 791, which was signed into law in 1991, required that all health care staff record pain assessment each time that vital signs are recorded for each patient, making it the fifth vital sign. In 2016, both the American Medical Association and the Physicians at the American Academy of Family Physicians dropped pain as the fifth vital sign. Veterans Affairs, which was used as the model for AB 791, has also stopped requiring that pain be assessed as the fifth vital sign.

ANALYSIS

This bill would, beginning July 1, 2018, authorize a pharmacist to dispense a Schedule II controlled substance, including opioids, as a partial fill if requested by the patient or prescriber. This bill would specify that subsequent fills, until the original prescription is completely dispensed, shall occur at the pharmacy where the original prescription was

partially filled. This bill would require the full prescription to be dispensed not more than 30 days after the date on which the prescription was written. Thirty-one days after the date on which the prescription was written, the prescription shall expire and no more of the drug shall be dispensed without a subsequent prescription. This bill would require the pharmacist to record in the state prescription drug monitoring program only the actual amounts of the drug dispensed. This bill would require the pharmacist to record the date and amount of each partial fill in a readily retrievable form on the original prescription, and shall include the initials of the pharmacist who dispensed each partial fill.

This bill would allow the pharmacist to charge a professional dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription. This bill would require a health care service plan to prorate a copayment for a partial fill and would not allow this copayment to be considered an excess payment recoverable by the plan or a basis for denial of the pharmacy's claim for reimbursement for the medication.

This bill would also remove the requirement that pain be assessed at the same time as vital signs, and would instead include pain as an item to be assessed, which shall be noted in the patient's chart.

Per the author's office, this bill seeks to update California statute to reflect the new partial fill authority created by CARA. Allowing for partial fills will give the patient confidence that should his/her pain continue beyond the expected duration, he/she will be able to access appropriate pain relief without unnecessary delay. Conversely, should the patient only require the lowest dosage at the shortest duration, it will reduce the supply of unused medication available for misuse or diversion. In addition, this bill removes pain as the fifth vital sign, but maintains a requirement to assess pain in a manner that allows organizations and hospitals to set their own policies regarding which patient should have pain assessed based on the population served and services delivered.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will increase consumer protection by allowing for partial fills of opioids, which will likely reduce the supply of opioids that could potentially be misused or diverted. This bill takes reasonable steps to address the opioid epidemic and will further the Board's mission of consumer protection.

FISCAL: None to the Board

SUPPORT: California Medical Association (Sponsor)
California Academy of Family Physicians
California Academy of PAs
California Hospital Association
California Society of Interventional Pain Physicians
Consumer Attorneys of California
Medical Board of California

OPPOSITION: None on file

AMENDED IN SENATE JULY 3, 2017
AMENDED IN SENATE JUNE 21, 2017
AMENDED IN SENATE JUNE 15, 2017
AMENDED IN ASSEMBLY APRIL 27, 2017
AMENDED IN ASSEMBLY APRIL 19, 2017
AMENDED IN ASSEMBLY MARCH 21, 2017
CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1048

Introduced by Assembly Member Arambula

February 16, 2017

An act to add Section 4052.10 to the Business and Professions Code, to amend Section 1254.7 of, and to add Section 1367.43 to, the Health and Safety Code, and to add Section 10123.203 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1048, as amended, Arambula. Health care: pain management and Schedule II drug prescriptions.

(1) The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. A violation of the Pharmacy Law is a crime.

This bill ~~would~~ *would, beginning July 1, 2018*, authorize a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber. The bill would require the pharmacy to retain the original prescription, with a notation of how much of the prescription has been filled, the date and amount of each partial fill, and the initials of the pharmacist dispensing each partial fill, until the prescription has been fully dispensed. The bill would authorize a pharmacist to charge a *professional* dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription. By creating a new crime, this bill would impose a state-mandated local program.

(2) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires a health facility, as a condition of licensure, to include pain as an item to be assessed at the same time vital signs are taken and to ensure that pain assessment is performed in a consistent manner that is appropriate to the patient.

This bill would remove the requirement that pain be assessed at the same time as vital signs.

(3) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plan contracts issued by health care service plans and health insurance policies issued by health insurers, including those that cover prescription drug benefits, as specified.

This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after ~~January~~ *July 1, 2018*, from allowing the health care service plan, the insurer, or the entity with which either contracts to administer prescription drug benefits from considering a copayment or any portion thereof, or the payment for the ingredient costs of the drug, paid to a pharmacy for a partial fill of a prescription, to be an excess payment recoverable by the plan, the insurer, or the contracting entity or a basis for denial of the pharmacy's claim for reimbursement for the medication. *The bill would also require a health care service plan and an insurer to prorate a copayment for a partial fill of a prescription.* By creating a new crime

under the Knox-Keene Act, this bill would impose a state-mandated local program.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 4052.10 is added to the Business and
2 Professions Code, to read:

3 4052.10. (a) A pharmacist may dispense a Schedule II
4 controlled substance, as listed in Section 11055 of the Health and
5 Safety Code, as a partial fill if requested by the patient or the
6 prescriber.

7 (b) If a pharmacist dispenses a partial fill on a prescription
8 pursuant to this section, the pharmacy shall retain the original
9 prescription, with a notation of how much of the prescription has
10 been filled, until the prescription has been fully dispensed. The
11 total quantity dispensed shall not exceed the total quantity
12 prescribed.

13 (c) Subsequent fills, until the original prescription is completely
14 dispensed, shall occur at the pharmacy where the original
15 prescription was partially filled. The full prescription shall be
16 dispensed not more than 30 days after the date on which the
17 prescription was written. Thirty-one days after the date on which
18 the prescription was written, the prescription shall expire and no
19 more of the drug shall be dispensed without a subsequent
20 prescription.

21 (d) The pharmacist shall record in the state prescription drug
22 monitoring program only the actual amounts of the drug dispensed.

23 (e) The pharmacist shall record the date and amount of each
24 partial fill in a readily retrievable form and on the original
25 prescription, and shall include the initials of the pharmacist who
26 dispensed each partial fill.

27 (f) A pharmacist may charge a ~~dispensing fee~~ *professional*
28 *dispensing fee, as defined in Section 14105.45 of the Welfare and*

1 *Institutions Code*, to cover the actual supply and labor costs
2 associated with dispensing each partial fill associated with the
3 original prescription.

4 (g) This section is not intended to conflict with or supersede
5 any other requirement established for the prescription of a Schedule
6 II controlled substance.

7 (h) For purposes of this section, the following definitions apply:

8 (1) “Original prescription” means the prescription presented by
9 the patient to the pharmacy or submitted electronically to the
10 pharmacy.

11 (2) “Partial fill” means a part of a prescription filled that is of
12 a quantity less than the entire prescription.

13 (i) *This section shall become operative on July 1, 2018.*

14 SEC. 2. Section 1254.7 of the Health and Safety Code is
15 amended to read:

16 1254.7. (a) It is the intent of the Legislature that pain be
17 assessed and treated promptly, effectively, and for as long as pain
18 persists.

19 (b) A health facility licensed pursuant to this chapter shall, as
20 a condition of licensure, include pain as an item to be assessed.
21 The health facility shall ensure that pain assessment is performed
22 in a consistent manner that is appropriate to the patient. The pain
23 assessment shall be noted in the patient’s chart.

24 SEC. 3. Section 1367.43 is added to the Health and Safety
25 Code, to read:

26 1367.43. (a) A health care service plan contract that is issued,
27 amended, or renewed on or after ~~January~~ July 1, 2018, shall not
28 allow the health care service plan or the entity with which it
29 contracts to administer prescription drug benefits for ~~enrollees~~;
30 *enrollees* to consider a copayment or any portion thereof, or the
31 payment for the ingredient costs of the drug, paid to a pharmacy
32 for a partial fill of a prescription pursuant to Section 4052.10 of
33 the Business and Professions ~~Code~~; *Code* to be an excess payment
34 recoverable by the plan or its contracting entity or a basis for denial
35 of the pharmacy’s claim for reimbursement for the medication.

36 (b) *A health care service plan shall prorate a copayment for a*
37 *partial fill of a prescription dispensed pursuant to Section 4052.10*
38 *of the Business and Professions Code.*

39 SEC. 4. Section 10123.203 is added to the Insurance Code, to
40 read:

1 10123.203. (a) A health insurance policy that is issued,
2 amended, or renewed on or after ~~January~~ July 1, 2018, shall not
3 allow the insurer or the entity with which it contracts to administer
4 prescription drug benefits for the ~~insured~~, *insured* to consider a
5 copayment or any portion thereof, or the payment for the ingredient
6 costs of the drug, paid to a pharmacy for a partial fill of a
7 prescription pursuant to Section 4052.10 of the Business and
8 Professions ~~Code~~, *Code* to be an excess payment recoverable by
9 the insurer or its contracting entity or a basis for denial of the
10 pharmacy's claim for reimbursement for the medication.

11 (b) *An insurer shall prorate a copayment for a partial fill of a*
12 *prescription dispensed pursuant to Section 4052.10 of the Business*
13 *and Professions Code.*

14 SEC. 5. No reimbursement is required by this act pursuant to
15 Section 6 of Article XIII B of the California Constitution because
16 the only costs that may be incurred by a local agency or school
17 district will be incurred because this act creates a new crime or
18 infraction, eliminates a crime or infraction, or changes the penalty
19 for a crime or infraction, within the meaning of Section 17556 of
20 the Government Code, or changes the definition of a crime within
21 the meaning of Section 6 of Article XIII B of the California
22 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1204
Author: Mayes
Bill Date: March 28, 2017, Amended
Subject: Public Health: Emergency Prescriptions
Sponsor: Author
Position: Neutral if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician to prescribe a one-month supply of a life-saving medication, as defined, to a patient to be stored for the use of that patient in case of a natural disaster or other emergency.

ANALYSIS

This bill would define life-saving medication to include, but is not limited to, medication necessary to save the life of a patient whose life is at risk due to illnesses such as cancer, heart disease, diabetes, stroke, and other illnesses in which the failure to administer the medication can result in the death of the patient. A life-saving medication does not include medications that are primarily prescribed to relieve pain.

According to the author's office this bill is a district bill and the purpose is to ensure that once a year a doctor can prescribe a life-saving medication, over and above what is normally prescribed, so the patient can store that medication at home in case of a natural disaster or other emergency that prevents the individual from going to the pharmacy and having their prescription filled.

Ensuring that patients have access to life-saving medications is important and will ensure that these patient's lives are not at risk. However, the bill as written does not make it clear that the 30-day supply is in addition to their regularly prescribed dosage. In addition, although this bill does say that life-saving medications do not include medications that are primarily prescribed to relieve pain, this bill should specifically prohibit controlled substances used for pain management. The Board will be neutral on this bill if it is amended to address these issues and to ensure that expired drugs are disposed of properly.

FISCAL: None
SUPPORT: None on file
OPPOSITION: None on file

AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1204

Introduced by Assembly Member Mayes

February 17, 2017

An act to ~~amend Section 1797.1 of~~ *add Chapter 13 (commencing with Section 1799.300) to Division 2.5 of the Health and Safety Code,* relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1204, as amended, Mayes. Public health: emergency ~~medical services; prescriptions.~~

Existing law governs the practice of medicine and the issuance of prescription drugs.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, states that it is the policy of the State of California to ensure the provision of effective and efficient emergency medical care.

This bill would authorize a licensed physician to prescribe a one-month supply of a life-saving medication, as described, to a patient to be stored for the use of that patient in case of a natural disaster or other emergency.

~~Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, makes findings and declarations regarding the establishment of the Emergency Medical Services Authority.~~

~~This bill would make a technical, nonsubstantive change to these provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Chapter 13 (commencing with Section 1799.300)
2 is added to Division 2.5 of the Health and Safety Code, to read:

3
4 CHAPTER 13. EMERGENCY PRESCRIPTIONS

5
6 1799.300. For purposes of this chapter, a “life-saving
7 medication” includes, but is not limited to, medication necessary
8 to save the life of a patient whose life is at risk due to illnesses
9 such as cancer, heart disease, diabetes, stroke, and other illnesses
10 in which the failure to administer the medication can result in the
11 death of the patient. A life-saving medication does not include
12 medications that are primarily prescribed to relieve pain.

13 1799.301. Notwithstanding any other law, a licensed physician
14 may prescribe a one-month supply of a life-saving medication to
15 a patient to be stored for the use of that patient in case of a natural
16 disaster or other emergency.

17 SECTION 1. Section 1797.1 of the Health and Safety Code is
18 amended to read:

19 ~~1797.1. The Legislature finds and declares that it is the intent~~
20 ~~of this act to provide the state with a statewide system for~~
21 ~~emergency medical services by establishing within the California~~
22 ~~Health and Human Services Agency, the Emergency Medical~~
23 ~~Services Authority, which is responsible for the coordination and~~
24 ~~integration of all state activities concerning emergency medical~~
25 ~~services.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1340
Author: Maienschein
Bill Date: June 14, 2017, Amended
Subject: Continuing Medical Education: Mental and Physical Health Care
Integration
Sponsor: The Steinberg Institute
Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill would allow for an optional continuing medical education (CME) course in integrating mental and physical health care in primary care settings, especially at it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment.

BACKGROUND

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two-year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 hours in the subject of pain management and the treatment of the terminally ill. There is also a mandate in existing law that requires general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME in a course in the field of geriatric medicine or the care of older patients.

Existing CME courses approved by the Medical Board of California's (Board) Licensing Program include:

- Programs accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), the American Medical Association (AMA), and the Accreditation Council for Continuing Medical Education (ACCME) that qualify for AMA PRA Category 1 Credit(s)TM;
- Programs that qualify for prescribed credit from the American Academy of Family Physicians (AAFP); and
- Other programs offered by other organizations and institutions acceptable to the Board.

ANALYSIS

This bill requires the Board, when determining CME requirements, to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and

young adults and their appropriate care and treatment. According to the sponsor, it is imperative that all medical professionals are trained in recognizing the early signs of mental health issues in children and young adults. The sponsor believes this is especially important for pediatricians and general practitioners to ensure they are fully educated in identifying mental health concerns and appropriately treating them. The sponsor states that 50 percent of all cases of mental illness begin by age 14 and by age 24 the rate is 75 percent, so the need to equip physicians with the tools and knowledge to meet the demands of these young people is paramount.

Although the Board has historically opposed mandated CME, this bill would not mandate particular CME for physicians. This bill only requires the Board to consider a course on integrating mental and physical health care in primary care settings. The Board does not track employment information for physicians, so the Board would not know which physicians practice in primary care settings. However, if the Board decides that it is important to get out information to physicians on this particular type of CME to encourage attendance in these CME courses, it could include an article in its Newsletter or put information out on the Board's website. The Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: The Steinberg Institute (Sponsor)
California Access Coalition
California Council of Community Behavioral Health Agencies
California Psychiatric Association
March of Dimes Foundation

OPPOSITION: None on file

AMENDED IN SENATE JUNE 14, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1340

Introduced by Assembly Member Maienschein
(Principal coauthor: Assembly Member Thurmond)
(Coauthors: Assembly Members Gallagher, Mathis, and Gipson
***Gipson, and Mathis*)**
(Coauthors: Senators Bates and Hertzberg)

February 17, 2017

An act to amend Section 2191 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1340, as amended, Maienschein. Continuing medical education: mental and physical health care integration.

The Medical Practice Act requires the Medical Board of California to adopt and administer standards for the continuing education of licensed physicians and surgeons and requires the board to require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at specified intervals. The act requires the board, in determining its continuing education requirements, to consider including courses on specified matters.

This bill would require the board to consider including in its continuing education requirements a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues *and exposure to trauma* in children and young adults and their appropriate care and treatment.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human sexuality as defined in Section 2090 and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The board shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The board shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The board shall encourage every physician and surgeon to take nutrition as part of his or her continuing education, particularly a physician and surgeon involved in primary care.

(e) The board shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the board shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the board shall consider including a course in the special care needs of drug addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the board shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse

1 detection or treatment, that requirement shall be met by each
2 licensee within no more than four years from the date the
3 requirement is imposed.

4 (i) In determining its continuing education requirements, the
5 board shall consider including a course in the special care needs
6 of individuals and their families facing end-of-life issues, including,
7 but not limited to, all of the following:

8 (1) Pain and symptom management.

9 (2) ~~The psycho-social~~ *psychosocial* dynamics of death.

10 (3) Dying and bereavement.

11 (4) Hospice care.

12 (j) In determining its continuing education requirements, the
13 board shall give its highest priority to considering a course on pain
14 management.

15 (k) In determining its continuing education requirements, the
16 board shall consider including a course in geriatric care for
17 emergency room physicians and surgeons.

18 (l) In determining its continuing education requirements, the
19 board shall consider including a course in integrating mental and
20 physical health care in primary care settings, especially as it
21 pertains to early identification of mental health issues *and exposure*
22 *to trauma* in children and young adults and their appropriate care
23 and treatment.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1368
Author: Calderon
Bill Date: June 29, 2017, Amended
Subject: Health Professionals: Authorization Forms
Sponsor: California Academy of Physician Assistants (CAPA)
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the Department of Health Care Services (DHCS) to allow a physician assistant (PA) or a nurse practitioner (NP) to sign any authorization form required by DHCS for benefits and services under the Medi-Cal Program, the Genetically Handicapped Persons Program, and the Child Health Disability Prevention Program, provided the PA or NP is authorized by the supervising physician, or by the NP's standardized procedures or protocols, and if the physician and the PA or NP are each enrolled as Medi-Cal providers.

BACKGROUND:

The Physician Assistant Practice Act authorizes a PA to perform specified medical services when the services are rendered under the supervision of a licensed physician and surgeon. A PA may only provide those medical services which he or she is competent to perform and which are consistent with his or her education, training, and experience. A physician and PA must establish written guidelines or protocols for the adequate supervision of PAs.

Under the Nurse Practice Act, NPs hold a valid and active registered nursing license, possess a master's degree in a clinical field related to nursing or a graduate degree in nursing and have completed a nurse practitioner program approved by the Board of Registered Nursing. Generally, standardized procedures and protocols, developed in collaboration with physicians and surgeons and other health professionals, govern the types of medical services that can be provided by NPs.

PAs and NPs provide a wide breath of health care services in a variety of settings, including hospitals, community clinics, and private practice settings.

ANALYSIS

According to the sponsor, current law recognizes PAs as licensed health care providers that practice medicine under the supervision of a physician and act as an agent of the supervising physician when performing any authorized medical services. Specifically, Medi-Cal recognizes PAs as non-physician providers that render medical services under the general

supervision of a physician. PAs must be enrolled with the Department of Health Care Services Provider Enrollment Division for reimbursement, ordering, referring and prescribing purposes. Further, the Medi-Cal program recognizes PAs as primary care providers. However, there are many forms that require a physician (M.D. or D.O) signature, even when a PA has performed the medical services. Requiring a physician signature on authorization forms creates delays in access to care and supplies to meet basic health care needs such as: incontinence supplies, non-urgent medical transport, physical therapy and other critical patient needs.

Allowing PAs and NPs to sign off on authorization forms for benefits and services under the Medi-Cal Program, the Genetically Handicapped Persons Program, and the Child Health Disability Prevention Program seems reasonable, as PAs and NPs are already recognized as primary care providers in Medi-Cal. This bill would only allow PAs or NPs to sign off on authorization forms if their physician supervisor or their standardized protocols and procedures has designated them to do so. This may prevent delays in access to care for California patients and will not compromise consumer protection. The Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: CAPA (sponsor)
California Academy of Family Physicians
California Association for Nurse Practitioners
California Council of Community Behavioral Health Agencies
California Health +Advocates

OPPOSITION: None on File

AMENDED IN SENATE JUNE 29, 2017

AMENDED IN SENATE JUNE 19, 2017

AMENDED IN ASSEMBLY APRIL 20, 2017

AMENDED IN ASSEMBLY MARCH 30, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1368

Introduced by Assembly Member Calderon

February 17, 2017

An act to add Sections ~~123823, 124037, 124037~~ and 125186 to the Health and Safety Code, and to add Section 14133.91 to the Welfare and Institutions Code, relating to health professionals.

LEGISLATIVE COUNSEL'S DIGEST

AB 1368, as amended, Calderon. Health professionals: authorization forms.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. Existing law provides for a schedule of benefits and services under the Medi-Cal program, subject to utilization controls. Existing law provides that specified utilization controls may be applied to any specific service or group of services that are subject to utilization controls, including prior authorization requirements. Existing law also requires the department to administer other health programs, including the ~~California Children's Services Program~~, the Genetically Handicapped Persons ~~Program~~, ~~Program~~ and the Child Health and Disability Prevention Program.

This bill would require the department to allow a physician assistant or a nurse practitioner to sign any authorization form required by the department for benefits and services under the Medi-Cal program, the Genetically Handicapped Persons Program, or the Child Health and Disability Prevention Program, ~~and to allow a nurse practitioner to sign any required authorization form, as specified, under the California Children's Services Program,~~ subject to specified criteria, including, among others, that the physician and the designated physician assistant or nurse practitioner are each enrolled as a Medi-Cal provider.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 ~~SECTION 1. Section 123823 is added to the Health and Safety~~
2 ~~Code, to read:~~

3 ~~123823. The department shall allow a nurse practitioner to sign~~
4 ~~any authorization form required by the department for benefits~~
5 ~~and services under this article, subject to both of the following:~~

6 ~~(a) The nurse practitioner is a CCS-paneled provider who is~~
7 ~~authorized by the supervising physician, or the nurse practitioner's~~
8 ~~standardized procedure or protocol, to provide the service pursuant~~
9 ~~to his or her scope of practice.~~

10 ~~(b) The physician and the designated nurse practitioner are each~~
11 ~~enrolled as a Medi-Cal provider pursuant to Article 1.3~~
12 ~~(commencing with Section 14043) of Chapter 7 of Part 3 of~~
13 ~~Division 9 of the Welfare and Institutions Code.~~

14 ~~SEC. 2.~~

15 ~~SECTION 1. Section 124037 is added to the Health and Safety~~
16 ~~Code, to read:~~

17 ~~124037. The department shall allow a physician assistant or a~~
18 ~~nurse practitioner to sign any authorization form required by the~~
19 ~~department for benefits and services under this article, subject to~~
20 ~~both of the following:~~

21 ~~(a) The physician assistant or the nurse practitioner is authorized~~
22 ~~by the supervising physician, or the nurse practitioner's~~
23 ~~standardized procedure or protocol, to provide the service pursuant~~
24 ~~to his or her scope of practice.~~

25 ~~(b) The physician and the designated physician assistant or nurse~~
26 ~~practitioner are each enrolled as a Medi-Cal provider pursuant to~~

Article 1.3 (commencing with Section 14043) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

~~SEC. 3.~~

SEC. 2. Section 125186 is added to the Health and Safety Code, to read:

125186. The department shall allow a physician assistant or a nurse practitioner to sign any authorization form required by the department for benefits and services under this article, subject to both of the following:

(a) The physician assistant or the nurse practitioner is authorized by the supervising physician, or the nurse practitioner's standardized procedure or protocol, to provide the service pursuant to his or her scope of practice.

(b) The physician and the designated physician assistant or nurse practitioner are each enrolled as a Medi-Cal provider pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

~~SEC. 4.~~

SEC. 3. Section 14133.91 is added to the Welfare and Institutions Code, immediately following Section 14133.9, to read:

14133.91. The department shall allow a physician assistant or a nurse practitioner to sign any authorization form required by the department for benefits and services under this chapter, subject to both of the following:

(a) The physician and the designated physician assistant or nurse practitioner are each enrolled as a Medi-Cal provider pursuant to Article 1.3 (commencing with Section 14043).

(b) The physician assistant or the nurse practitioner is authorized by the supervising physician, or the nurse practitioner's standardized procedure or protocol, to provide the service pursuant to his or her scope of practice.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1512
Author: McCarty
Bill Date: May 9, 2017, Amended
Subject: Opioid Addiction Prevention and Rehabilitation Act
Sponsor: California Council of Community Behavioral Health Agencies
Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Opioid Addiction Prevention and Rehabilitation Act, which will be funded through a one cent per milligram surcharge on opioid distribution in California, effective July 1, 2018.

BACKGROUND:

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

The Medical Board of California (Board) developed a Prescribing Task Force that held multiple meetings to identify best practices, hear from speakers regarding this issue, and update the Board's Guidelines for Prescribing Controlled Substances for Pain. This task force had numerous meetings with interested parties and discussions with experts in the field of pain management to develop this document, which was adopted by the Board in November 2014. These Guidelines are intended to educate physicians on effective pain management in California by avoiding under treatment, overtreatment, or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. The Guidelines contain a significant amount of information and are supplemented with as many resources as practical via the appendices and links to websites that further assist a physician when prescribing controlled substances for pain. The Guidelines discuss several areas, including understanding pain, special patient populations, patient evaluation and risk stratification, consultation, treatment plan and objectives, patient consent, pain management agreements, counseling patient on overdose risk and response, initiating an opioid trial, ongoing patient assessment, and several other areas.

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

ANALYSIS

This bill would create the Opioid Prevention and Rehabilitation Program Fund (Fund) in the State Treasury. This bill would state the intent of the Legislature is to enact legislation that would provide for distribution of the moneys in the fund for addiction prevention and rehabilitation programs.

This bill would, on and after July 1, 2018, impose a tax upon the distribution of opioids by a manufacturer to a wholesaler, at the rate of one cent per milligram of active opioid ingredient. The wholesaler shall collect the tax from the manufacturer and shall separately state the amount of the tax imposed under this part on the purchase order, which shall be given by the wholesaler to the manufacturer at the time of sale. The wholesaler shall remit the tax to the Board of Equalization (BOE), who would collect the tax pursuant to existing law. The tax imposed would be due and payable to the BOE on or before the last day of the month next succeeding each calendar quarter. Returns shall be filed with BOE using electronic media. All taxes, interest, penalties, and other amounts collected, less refunds and BOE's cost of administration, shall be deposited in the Fund.

According to the author, addiction is an issue that affects all types of people regardless of their ethnicity, age, social class, gender, or where they live. The barriers of access to treatment are unique to every patient and every county. Despite the high level of need, California's capacity for treatment services is not keeping pace. From 2010-2014, more than 87% of those dependent on or abusing illicit drugs did not have access to the care they needed. Despite more Californians enrolled in healthcare programs, millions go unserved and cannot access drug treatment programs.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will impose a tax upon the distribution of opioids by a manufacturer to a wholesaler, which seems to be a reasonable funding source to contribute to the

growing opioid abuse epidemic. This bill will help collect funding for addiction prevention and rehabilitation programs, which is much needed in California. This bill will increase awareness and furthers the Board's mission of consumer protection. The Board will support this bill if it is amended to ensure that the tax is not passed on to the consumers.

FISCAL: None to the Board

SUPPORT: California Council of Community Behavioral Health Agencies (Sponsor); California Consortium of Addiction Programs and Professionals; California Society of Addiction Medicine; County Behavioral Health Directors Association of California; Medical Board of California (if amended); and Transitions Clinic

OPPOSITION: California Taxpayers Association
Healthcare Distribution Alliance

AMENDED IN ASSEMBLY MAY 9, 2017
AMENDED IN ASSEMBLY APRIL 25, 2017
AMENDED IN ASSEMBLY APRIL 17, 2017
AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1512

Introduced by Assembly Member McCarty

February 17, 2017

An act to add Division 10.4 (commencing with Section 11740) to the Health and Safety Code, and to add Part 14.3 (commencing with Section 33001) to Division 2 of the Revenue and Taxation Code, relating to taxation, *and making an appropriation therefor*, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

AB 1512, as amended, McCarty. Opioid Addiction Prevention and Rehabilitation Act.

Existing law imposes various fees and taxes, including taxes on the privilege of engaging in certain activities. The Fee Collection Procedures Law, the violation of which is a crime, provides procedures for the collection of certain fees and surcharges.

Under this bill, the Opioid Addiction Prevention and Rehabilitation Act would impose a tax on and after ~~January~~ *July* 1, 2018, upon the distribution of opioids by ~~every person including, but not limited to, a manufacturer or wholesaler, that makes the first sale in this state of opioids, where the sale is for the purpose of resale in the regular course of business, a manufacturer to a wholesaler from the manufacturer, as~~

those terms are defined, at the rate of \$0.01 per milligram of active opioid ingredient. *The bill would require the wholesaler to collect the tax and remit it to the State Board of Equalization.* The tax would be administered by the State Board of Equalization and would be collected pursuant to the procedures set forth in the Fee Collection Procedures Law, which sets forth requirements for registration, returns, payments, penalties, interest, determinations and redeterminations, collections, overpayments and refunds, administration and confidentiality, and violations. By expanding the application of the Fee Collection Procedures Law, the violation of which is a crime, this bill would impose a state-mandated local program.

This bill would require the board to deposit all taxes, interest, penalties, and other amounts collected, ~~less-refunds~~, *refunds and the board's costs of administration*, into the Opioid Prevention and Rehabilitation Program Fund, which this bill would create. *By authorizing the use of moneys collected pursuant to this bill for these purposes, the bill would make an appropriation.* The bill would state the intent of the Legislature to enact legislation that would provide for distribution of the moneys in the fund for addiction prevention and rehabilitation programs.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $\frac{2}{3}$ of the membership of each house of the Legislature.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would take effect immediately as a tax levy.

Vote: $\frac{2}{3}$. Appropriation: ~~no~~-yes. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Division 10.4 (commencing with Section 11740)
- 2 is added to the Health and Safety Code, to read:

DIVISION 10.4. OPIOID PREVENTION AND
REHABILITATION PROGRAM FUND

11740. (a) There is hereby created in the State Treasury the
Opioid Prevention and Rehabilitation Program Fund.

(b) It is the intent of the Legislature to enact legislation that
would provide for distribution of the moneys in the fund for
addiction prevention and rehabilitation programs.

SEC. 2. Part 14.3 (commencing with Section 33001) is added
to Division 2 of the Revenue and Taxation Code, to read:

PART 14.3. OPIOID ADDICTION PREVENTION AND
REHABILITATION ACT

33001. This part shall be known and may be cited as the Opioid
Addiction Prevention and Rehabilitation Act.

33002. For purposes of this part:

(a) “Active opioid ingredient” means that portion of a product
that is an opioid.

(b) “Distribution” means the sale of untaxed opioids in this
state.

(c) “In this state” means within the exterior limits of the State
of California and includes all territory within these limits owned
by or ceded to the United States.

(d) “*Manufacturer*” means any person, whether or not located
in this state, who manufactures opioids for distribution in this
state.

~~(d)~~

(e) “Opiate” means the dried, condensed juice of a poppy,
Papaver somniferum, that has a narcotic, soporific, analgesic, and
astringent effect.

~~(e)~~

(f) “Opioid” means an opiate or any synthetic or semisynthetic
narcotic that has opiatelike activities but is not derived from opium
and has effects similar to natural opium alkaloids, and any
derivatives thereof.

~~(f)~~

(g) “Person” means person as defined in Section 55002.

~~(g)~~

1 (h) “Sale” means any transfer of title or possession for a
2 consideration, exchange, or barter, in any manner or by any means.

3 ~~(h)~~

4 (i) “Untaxed opioid” means any opioid which has not yet been
5 distributed in a manner as to result in a tax liability under this part.

6 (j) “Wholesaler” means any person who engages in this state
7 in the making of sales for resale of opioids.

8 33003. (a) On and after ~~January~~ July 1, 2018, a tax is hereby
9 imposed upon the distribution of opioids by ~~every person including,~~
10 ~~but not limited to, a manufacturer or wholesaler, that makes the~~
11 ~~first sale in this state of opioids, where the sale is for the purpose~~
12 ~~of resale in the regular course of business, a manufacturer to a~~
13 ~~wholesaler,~~ at the rate of one cent (\$0.01) per milligram of active
14 opioid ingredient.

15 (b) *The wholesaler shall collect the tax from the manufacturer*
16 *and shall separately state the amount of the tax imposed under*
17 *this part on the purchase order, which shall be given by the*
18 *wholesaler to the manufacturer at the time of sale. The wholesaler*
19 *shall remit the tax to the board.*

20 33004. There shall be exempt from the taxes imposed by this
21 part the distribution to a person if the state is prohibited from taxing
22 that sale under the Constitution or laws of the United States or
23 under the Constitution of this state.

24 33005. (a) The board shall collect the tax pursuant to the Fee
25 Collection Procedures Law (Part 30 (commencing with Section
26 55001) of Division 2 of the Revenue and Taxation Code). For
27 purposes of administration of the tax pursuant to this part,
28 references in the Fee Collection Procedures Law to “feepayer”
29 and “fee” shall include “taxpayer” and “tax.”

30 (b) The board may adopt any regulations necessary or
31 appropriate to carry out the purposes of this part.

32 (c) The tax imposed by this part shall be due and payable to the
33 board on or before the last day of the month next succeeding each
34 calendar quarter, together with a return for that calendar quarter.
35 *Returns shall be filed with the board using electronic media and*
36 *authenticated in a form or pursuant to methods as may be*
37 *prescribed by the board.*

38 33006. All taxes, interest, penalties, and other amounts
39 collected pursuant to this part, ~~less refunds,~~ *refunds and the board’s*
40 *costs of administration,* shall be deposited into the Opioid

1 Prevention and Rehabilitation Program Fund established by Section
2 11740 of the Health and Safety Code.

3 SEC. 3. No reimbursement is required by this act pursuant to
4 Section 6 of Article XIII B of the California Constitution because
5 the only costs that may be incurred by a local agency or school
6 district will be incurred because this act creates a new crime or
7 infraction, eliminates a crime or infraction, or changes the penalty
8 for a crime or infraction, within the meaning of Section 17556 of
9 the Government Code, or changes the definition of a crime within
10 the meaning of Section 6 of Article XIII B of the California
11 Constitution.

12 SEC. 4. This act provides for a tax levy within the meaning of
13 Article IV of the California Constitution and shall go into
14 immediate effect.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1560
Author: Friedman
Bill Date: July 3, 2017, Amended
Subject: Nurse Practitioners: Certified Nurse-Midwives: Physician Assistants;
Physician and Surgeon Supervision
Sponsor: California Association for Nurse Practitioners (CANP)
Position: Oppose Unless Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician to supervise up to 12 furnishing nurse practitioners (NPs), certified nurse-midwives (CNMs), and physician assistants (PAs) at any one time.

ANALYSIS:

Existing law, limits the number of NPs who are furnishing or ordering drugs, PAs, and CNMS that may be supervised by a physician, to four for each category of mid-level practitioner. This means a physician could supervise four NPs, four PAs and four CNMS for a total of 12 mid-level practitioners. This bill would allow a physician to supervise 12 mid-level practitioners total, but does not limit the type of mid-level practitioner, so a physician could supervise 12 NPs, 12 PAs, or 12 CNMs, instead of four of each type of mid-level practitioner.

According to the author's office, in many clinic systems where there are multiple clinic sites, but only one medical director on staff, this severely limits the number of NPs who can provide patient care. The author's office believes this bill will increase essential health care availability and improve efficiency.

Increasing the supervision ratio from four to 12 for the individual categories of mid-level practitioners may result in insufficient supervision. The current limit for physician supervision for each mid-level practitioner category is four, with a total limit of 12. These mid-level practitioners are well qualified to provide medical care when practicing under physician supervision. The standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. Board staff suggests that raising the limit from four to six for each category of mid-level practitioner seems reasonable. The total limit could still be 12 as it is currently, but allowing a physician to supervise two more PAs, NPs, or CNMs would not negatively impact patient care, and would still maintain the current limit of 12. Board staff suggests the Board oppose this bill unless it is amended to cap the number of PAs, NPs, and CNMS a physician can supervise at six for each category of mid-level practitioner, and keep

the total cap at 12 mid-level practitioners total that a physician can supervise.

FISCAL: None

SUPPORT: CANP (Sponsor); Association of California Healthcare Districts; Bay Area Council; California Academy of PAs; California Council of Community Behavioral Health Agencies; and California Health Advocates

OPPOSITION: California Chapter of American College of Cardiology
California Society of Plastic Surgeons
Union of American Physicians and Dentists

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE JULY 3, 2017
AMENDED IN ASSEMBLY MAY 8, 2017
AMENDED IN ASSEMBLY MARCH 21, 2017
CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1560

Introduced by Assembly Member Friedman

February 17, 2017

An act to amend Sections 2746.51, 2836.1, 3516, and 3516.5 of, and to add Sections 2746.54 and 2836.4 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST

AB 1560, as amended, Friedman. Nurse practitioners: ~~certified nurse midwives~~: *certified nurse-midwives*: physician assistants: physician and surgeon supervision.

The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. The act authorizes a nurse practitioner to, among other things, furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision. The act prohibits a physician and surgeon from supervising more than 4 nurse practitioners at one time for purposes of furnishing drugs or devices.

Existing law authorizes the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to any person licensed under the Nursing Practice Act that meets certain qualifications. Existing law authorizes a ~~certified nurse-midwife~~ *certified nurse-midwife* to, among other things, furnish or order drugs and devices under specified circumstances subject to physician and surgeon supervision. Existing

law prohibits a physician and surgeon from supervising more than 4 ~~certified-nurse-midwives~~ *certified nurse-midwives* at one time for purposes of furnishing or ordering drugs or devices.

The Physician Assistance Practice Act provides for the licensure and regulation of physician assistants by the Physician Assistant Board, which is within the jurisdiction of the Medical Board of California. The act authorizes a physician assistant licensed by the Physician Assistant Board to be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision. The act prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time, except as specified.

This bill would instead prohibit a physician and surgeon from supervising more than ~~18~~ 12 nurse practitioners, ~~certified-nurse-midwives~~, *certified nurse-midwives*, and physician assistants at any one ~~time~~. *time, as specified.*

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 2746.51 of the Business and Professions
- 2 Code is amended to read:
- 3 2746.51. (a) Neither this chapter nor any other law shall be
- 4 construed to prohibit a certified nurse-midwife from furnishing or
- 5 ordering drugs or devices, including controlled substances
- 6 classified in Schedule II, III, IV, or V under the California Uniform
- 7 Controlled Substances Act (Division 10 (commencing with Section
- 8 11000) of the Health and Safety Code), when all of the following
- 9 apply:
- 10 (1) The drugs or devices are furnished or ordered incidentally
- 11 to the provision of any of the following:
- 12 (A) Family planning services, as defined in Section 14503 of
- 13 the Welfare and Institutions Code.
- 14 (B) Routine health care or perinatal care, as defined in
- 15 subdivision (d) of Section 123485 of the Health and Safety Code.
- 16 (C) Care rendered, consistent with the certified nurse-midwife's
- 17 educational preparation or for which clinical competency has been
- 18 established and maintained, to persons within a facility specified
- 19 in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the

1 Health and Safety Code, a clinic as specified in Section 1204 of
2 the Health and Safety Code, a general acute care hospital as defined
3 in subdivision (a) of Section 1250 of the Health and Safety Code,
4 a licensed birth center as defined in Section 1204.3 of the Health
5 and Safety Code, or a special hospital specified as a maternity
6 hospital in subdivision (f) of Section 1250 of the Health and Safety
7 Code.

8 (2) The drugs or devices are furnished or ordered by a certified
9 nurse-midwife in accordance with standardized procedures or
10 protocols. For purposes of this section, standardized procedure
11 means a document, including protocols, developed and approved
12 by the supervising physician and surgeon, the certified
13 nurse-midwife, and the facility administrator or his or her designee.
14 The standardized procedure covering the furnishing or ordering
15 of drugs or devices shall specify all of the following:

16 (A) Which certified nurse-midwife may furnish or order drugs
17 or devices.

18 (B) Which drugs or devices may be furnished or ordered and
19 under what circumstances.

20 (C) The extent of physician and surgeon supervision.

21 (D) The method of periodic review of the certified
22 nurse-midwife's competence, including peer review, and review
23 of the provisions of the standardized procedure.

24 (3) If Schedule II or III controlled substances, as defined in
25 Sections 11055 and 11056 of the Health and Safety Code, are
26 furnished or ordered by a certified nurse-midwife, the controlled
27 substances shall be furnished or ordered in accordance with a
28 patient-specific protocol approved by the treating or supervising
29 physician and surgeon. For Schedule II controlled substance
30 protocols, the provision for furnishing the Schedule II controlled
31 substance shall address the diagnosis of the illness, injury, or
32 condition for which the Schedule II controlled substance is to be
33 furnished.

34 (4) The furnishing or ordering of drugs or devices by a certified
35 nurse-midwife occurs under physician and surgeon supervision.:
36 *For purposes of this section, no physician and surgeon shall*
37 *supervise more certified nurse-midwives than allowed by Section*
38 *2746.54 at one time.* Physician and surgeon supervision shall not
39 be construed to require the physical presence of the physician, but
40 does include all of the following:

1 (A) Collaboration on the development of the standardized
2 procedure or protocol.

3 (B) Approval of the standardized procedure or protocol.

4 (C) Availability by telephonic contact at the time of patient
5 examination by the certified nurse-midwife.

6 (b) (1) The furnishing or ordering of drugs or devices by a
7 certified nurse-midwife is conditional on the issuance by the board
8 of a number to the applicant who has successfully completed the
9 requirements of paragraph (2). The number shall be included on
10 all transmittals of orders for drugs or devices by the certified
11 nurse-midwife. The board shall maintain a list of the certified
12 nurse-midwives that it has certified pursuant to this paragraph and
13 the number it has issued to each one. The board shall make the list
14 available to the California State Board of Pharmacy upon its
15 request. Every certified nurse-midwife who is authorized pursuant
16 to this section to furnish or issue a drug order for a controlled
17 substance shall register with the United States Drug Enforcement
18 Administration.

19 (2) The board has certified in accordance with paragraph (1)
20 that the certified nurse-midwife has satisfactorily completed a
21 course in pharmacology covering the drugs or devices to be
22 furnished or ordered under this section. The board shall establish
23 the requirements for satisfactory completion of this paragraph.

24 (3) A physician and surgeon may determine the extent of
25 supervision necessary pursuant to this section in the furnishing or
26 ordering of drugs and devices.

27 (4) A copy of the standardized procedure or protocol relating
28 to the furnishing or ordering of controlled substances by a certified
29 nurse-midwife shall be provided upon request to any licensed
30 pharmacist who is uncertain of the authority of the certified
31 nurse-midwife to perform these functions.

32 (5) Certified nurse-midwives who are certified by the board and
33 hold an active furnishing number, who are currently authorized
34 through standardized procedures or protocols to furnish Schedule
35 II controlled substances, and who are registered with the United
36 States Drug Enforcement Administration shall provide
37 documentation of continuing education specific to the use of
38 Schedule II controlled substances in settings other than a hospital
39 based on standards developed by the board.

1 (c) Drugs or devices furnished or ordered by a certified
2 nurse-midwife may include Schedule II controlled substances
3 under the California Uniform Controlled Substances Act (Division
4 10 (commencing with Section 11000) of the Health and Safety
5 Code) under the following conditions:

6 (1) The drugs and devices are furnished or ordered in accordance
7 with requirements referenced in paragraphs (2) to (4), inclusive,
8 of subdivision (a) and in paragraphs (1) to (3), inclusive, of
9 subdivision (b).

10 (2) When Schedule II controlled substances, as defined in
11 Section 11055 of the Health and Safety Code, are furnished or
12 ordered by a certified nurse-midwife, the controlled substances
13 shall be furnished or ordered in accordance with a patient-specific
14 protocol approved by the treating or supervising physician and
15 surgeon.

16 (d) Furnishing of drugs or devices by a certified nurse-midwife
17 means the act of making a pharmaceutical agent or agents available
18 to the patient in strict accordance with a standardized procedure
19 or protocol. Use of the term “furnishing” in this section shall
20 include the following:

21 (1) The ordering of a drug or device in accordance with the
22 standardized procedure or protocol.

23 (2) Transmitting an order of a supervising physician and
24 surgeon.

25 (e) “Drug order” or “order” for purposes of this section means
26 an order for medication or for a drug or device that is dispensed
27 to or for an ultimate user, issued by a certified nurse-midwife as
28 an individual practitioner, within the meaning of Section 1306.03
29 of Title 21 of the Code of Federal Regulations. Notwithstanding
30 any other law, (1) a drug order issued pursuant to this section shall
31 be treated in the same manner as a prescription of the supervising
32 physician; (2) all references to “prescription” in this code and the
33 Health and Safety Code shall include drug orders issued by certified
34 nurse-midwives; and (3) the signature of a certified nurse-midwife
35 on a drug order issued in accordance with this section shall be
36 deemed to be the signature of a prescriber for purposes of this code
37 and the Health and Safety Code.

38 SEC. 2. Section 2746.54 is added to the Business and
39 Professions Code, to read:

1 2746.54. A physician and surgeon shall not supervise more
2 ~~than 18 certified nurse midwives;~~ *12 certified nurse-midwives*
3 *functioning under Section 2746.51,* ~~nurse—practitioners;~~
4 *practitioners functioning under Section 2836.1,* and physician
5 assistants licensed under Chapter 7.7 (commencing with Section
6 3500) at any one time.

7 SEC. 3. Section 2836.1 of the Business and Professions Code
8 is amended to read:

9 2836.1. Neither this chapter nor any other law shall be
10 construed to prohibit a nurse practitioner from furnishing or
11 ordering drugs or devices when all of the following apply:

12 (a) The drugs or devices are furnished or ordered by a nurse
13 practitioner in accordance with standardized procedures or
14 protocols developed by the nurse practitioner and the supervising
15 physician and surgeon when the drugs or devices furnished or
16 ordered are consistent with the practitioner's educational
17 preparation or for which clinical competency has been established
18 and maintained.

19 (b) The nurse practitioner is functioning pursuant to standardized
20 procedure, as defined by Section 2725, or protocol. The
21 standardized procedure or protocol shall be developed and
22 approved by the supervising physician and surgeon, the nurse
23 practitioner, and the facility administrator or the designee.

24 (c) (1) The standardized procedure or protocol covering the
25 furnishing of drugs or devices shall specify which nurse
26 practitioners may furnish or order drugs or devices, which drugs
27 or devices may be furnished or ordered, under what circumstances,
28 the extent of physician and surgeon supervision, the method of
29 periodic review of the nurse practitioner's competence, including
30 peer review, and review of the provisions of the standardized
31 procedure.

32 (2) In addition to the requirements in paragraph (1), for Schedule
33 II controlled substance protocols, the provision for furnishing
34 Schedule II controlled substances shall address the diagnosis of
35 the illness, injury, or condition for which the Schedule II controlled
36 substance is to be furnished.

37 (d) The furnishing or ordering of drugs or devices by a nurse
38 practitioner occurs under physician and surgeon supervision.
39 Physician and surgeon supervision shall not be construed to require
40 the physical presence of the physician, but does include (1)

1 collaboration on the development of the standardized procedure,
2 (2) approval of the standardized procedure, and (3) availability by
3 telephonic contact at the time of patient examination by the nurse
4 practitioner.

5 (e) (1) Drugs or devices furnished or ordered by a nurse
6 practitioner may include Schedule II through Schedule V controlled
7 substances under the California Uniform Controlled Substances
8 Act (Division 10 (commencing with Section 11000) of the Health
9 and Safety Code) and shall be further limited to those drugs agreed
10 upon by the nurse practitioner and physician and surgeon and
11 specified in the standardized procedure.

12 (2) When Schedule II or III controlled substances, as defined
13 in Sections 11055 and 11056, respectively, of the Health and Safety
14 Code, are furnished or ordered by a nurse practitioner, the
15 controlled substances shall be furnished or ordered in accordance
16 with a patient-specific protocol approved by the treating or
17 supervising physician. A copy of the section of the nurse
18 practitioner's standardized procedure relating to controlled
19 substances shall be provided, upon request, to any licensed
20 pharmacist who dispenses drugs or devices, when there is
21 uncertainty about the nurse practitioner furnishing the order.

22 (f) (1) The board has certified in accordance with Section
23 2836.3 that the nurse practitioner has satisfactorily completed a
24 course in pharmacology covering the drugs or devices to be
25 furnished or ordered under this section.

26 (2) A physician and surgeon may determine the extent of
27 supervision necessary pursuant to this section in the furnishing or
28 ordering of drugs and devices.

29 (3) Nurse practitioners who are certified by the board and hold
30 an active furnishing number, who are authorized through
31 standardized procedures or protocols to furnish Schedule II
32 controlled substances, and who are registered with the United
33 States Drug Enforcement Administration, shall complete, as part
34 of their continuing education requirements, a course including
35 Schedule II controlled substances based on the standards developed
36 by the board. The board shall establish the requirements for
37 satisfactory completion of this subdivision.

38 (g) Use of the term "furnishing" in this section, in health
39 facilities defined in Section 1250 of the Health and Safety Code,
40 shall include (1) the ordering of a drug or device in accordance

1 with the standardized procedure and (2) transmitting an order of
2 a supervising physician and surgeon.

3 (h) “Drug order” or “order” for purposes of this section means
4 an order for medication which is dispensed to or for an ultimate
5 user, issued by a nurse practitioner as an individual practitioner,
6 within the meaning of Section 1306.03 of Title 21 of the Code of
7 Federal Regulations. Notwithstanding any other provision of law,
8 (1) a drug order issued pursuant to this section shall be treated in
9 the same manner as a prescription of the supervising physician;
10 (2) all references to “prescription” in this code and the Health and
11 Safety Code shall include drug orders issued by nurse practitioners;
12 and (3) the signature of a nurse practitioner on a drug order issued
13 in accordance with this section shall be deemed to be the signature
14 of a prescriber for purposes of this code and the Health and Safety
15 Code.

16 SEC. 4. Section 2836.4 is added to the Business and Professions
17 Code, to read:

18 2836.4. A physician and surgeon shall not supervise more than
19 ~~18~~ 12 nurse-practitioners, ~~certified-nurse-midwives, practitioners~~
20 *functioning under Section 2836.1, certified nurse-midwives*
21 *functioning under Section 2746.51, and physician assistants*
22 licensed under Chapter 7.7 (commencing with Section 3500) at
23 any one time.

24 SEC. 5. Section 3516 of the Business and Professions Code is
25 amended to read:

26 3516. (a) Notwithstanding any other law, a physician assistant
27 licensed by the board shall be eligible for employment or
28 supervision by any physician and surgeon who is not subject to a
29 disciplinary condition imposed by the Medical Board of California
30 prohibiting that employment or supervision.

31 (b) A physician and surgeon shall not supervise more than ~~18~~
32 12 physician assistants, nurse practitioners licensed under Chapter
33 6 (commencing with Section ~~2700~~), *2700) and functioning under*
34 *Section 2836.1, and—certified-nurse—midwives certified*
35 *nurse-midwives* certified under Article 2.5 (commencing with
36 ~~Section 2746) of 2746) of Chapter 6 and functioning under Section~~
37 *2746.51* at any one time, except as provided in Section 3502.5.

38 (c) The Medical Board of California may restrict a physician
39 and surgeon to supervising specific types of physician assistants
40 including, but not limited to, restricting a physician and surgeon

1 from supervising physician assistants outside of the field of
2 specialty of the physician and surgeon.

3 SEC. 6. Section 3516.5 of the Business and Professions Code
4 is amended to read:

5 3516.5. (a) Notwithstanding any other law and in accordance
6 with regulations established by the Medical Board of California,
7 the director of emergency care services in a hospital with an
8 approved program for the training of emergency care physician
9 assistants, may apply to the Medical Board of California for
10 authorization under which the director may grant approval for
11 emergency care physicians on the staff of the hospital to supervise
12 emergency care physician assistants.

13 (b) The application shall encompass all supervising physicians
14 employed in that service.

15 (c) A violation of this section by the director of emergency care
16 services in a hospital with an approved program for the training
17 of emergency care physician assistants constitutes unprofessional
18 conduct within the meaning of Chapter 5 (commencing with
19 Section 2000).

20 (d) A violation of this section shall be grounds for suspension
21 of the approval of the director or disciplinary action against the
22 director or suspension of the approved program under Section
23 3527.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1612
Author: Burke
Bill Date: April 18, 2017, Amended
Subject: Certified Nurse Midwives: Supervision
Sponsor: California Nurse Midwives Association (CNMA)
United Nurses Association of California (UNAC)
Position: Oppose Unless Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would remove the physician supervision requirement for certified nurse midwives (CNMs) allowing CNMs to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn in a variety of settings, including the home setting.

BACKGROUND:

CNMs are registered nurses with a certificate to practice midwifery, who have acquired additional training in the field of obstetrics and are certified by the American College of Nurse Midwives. Like licensed midwives (LMs), CNMs can practice in homes, birth centers and clinics; however, CNMs can also practice in hospital settings. In 2012, CNMs attended approximately 8.5 percent of all births in California, the majority of these births took place in a hospital, and the remainder took place in free-standing birthing centers. It is estimated that ninety percent of CNM attended births take place in a hospital setting. CNMs are required to practice under the supervision of a physician; California is one of the six states that require physician supervision of CNMs.

Existing law authorizes a CNM, under physician supervision, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother, and immediate care for the newborn. Existing law authorizes a CNM to furnish and order drugs or devices incidental to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the CNM's education, and in accordance with standardized procedures and protocols with the supervising physician. Existing law also authorizes a CNM to perform and repair episiotomies and repair first-degree and second degree lacerations of the perineum in a licensed acute care hospital and licensed alternate birth center, if performed pursuant to protocols developed and approved by the supervising physician.

AB 1308 (Bonilla, Chapter 665) was signed into law in 2013 and removed the physician supervision requirement for LMs. There were specific requirements on what type of patients LMs can accept, those that meet the criteria for normal pregnancy and childbirth, as specified.

If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM must refer that client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk factors are not likely to significantly affect the course of pregnancy and childbirth. AB 1308 also allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to the practice of midwifery and consistent with the LMs scope of practice. AB 1308 was very narrow on what services could be provided and what patients LMs could accept. It also included other provisions related to hospital transfers and education program requirements.

ANALYSIS

This bill would authorize a CNM provide the same range of services they are now authorized to provide, but without physician supervision. This bill would allow CNMs to practice in a variety of settings, including the home setting. This bill would allow a CNM to consult, refer, or transfer care to a physician, as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. This bill would specify that nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications. This bill would state that the furnishing or ordering of drugs or devices by a CNM occurs under standardized procedures and protocols, but does not necessarily require physician supervision. This bill would allow a CNM to directly procure supplies and devices, to obtain and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a CNM and consistent with nurse-midwifery education preparation.

This bill would authorize a CNM to perform and repair episiotomies and to repair first degree and second degree lacerations of the perineum in the settings currently allowed, and in a birth center accredited by a national accrediting body approved by the Board of Registered Nursing and in a home setting. This bill would delete all requirements that those procedures be performed pursuant to protocols developed and approved by the supervising physician. This bill would require a CNM to provide emergency care to a patient when a physician is not available.

This bill removes physician supervision for CNMs. Although the Board was supportive of the bill in 2013 that removed physician supervisions for LMs, it was because the bill was very restricted and clear on what types of patients LMs could accept, and required physician consultation and approval for patients that did not meet the requirements. High risk patients cannot be accepted by an LM. This bill would allow a CNM to accept all patients, there are no clear limits on what types of patients a CNM could accept. This bill would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care and early detection and referral of complications. However, this bill does not define informed consent or when a CNM has to refer a patient to a physician and for what types of complications. In addition, it is also unknown how this bill would affect corporate practice, as the bill does not address this issue.

The Board's primary mission is consumer protection and this bill does not currently include parameters on independent CNM practice that would ensure consumer protection. As such, the Board is opposed to this bill unless it is amended to address the Board's concerns.

FISCAL: None to the Board

SUPPORT: CNMA (Sponsor)
UNAC (Sponsor)
California Hospital Association
California Association of Nurse Anesthetists
Maternal and Child Health Access
American Nurses Association California
California Families for Access to Midwives
2 individuals

OPPOSITION: California Medical Association
Medical Board of California (Unless Amended)

AMENDED IN ASSEMBLY APRIL 18, 2017

AMENDED IN ASSEMBLY MARCH 20, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1612

Introduced by Assembly Member Burke

February 17, 2017

An act to amend ~~Section 2746.2~~ *Sections 2746.5, 2746.51, and 2746.52* of the Business and Professions Code, relating to nursing.

LEGISLATIVE COUNSEL'S DIGEST

AB 1612, as amended, Burke. Nursing: ~~nurse-midwives: certified nurse-midwives: supervision.~~

~~The~~

(1) *The Nursing Practice Act provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing, which is within the Department of Consumer Affairs, and requires the board to issue a certificate to practice nurse-midwifery to a licensee who meets specified qualifications. That act requires each applicant for a certificate to show evidence satisfactory to the board that the applicant has met educational standards established by the board or has at least the equivalent thereof and authorizes the board to appoint a committee of qualified physicians and nurses to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters. authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn, and provides that the*

practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. The act makes the violation of any of its provisions punishable as a misdemeanor, as specified.

~~This bill would specify that evidence satisfactory to the board includes evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board and would remove from the authority of the committee the development of standards relating to ratios of nurse-midwives to supervising physicians. repeal the requirement that a certified nurse-midwife be under the supervision of a licensed physician and surgeon. The bill would authorize a certified nurse-midwife to consult, refer, or transfer care to a physician and surgeon as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. The bill would provide that a certified nurse-midwife practices within a variety of settings, including, but not limited to, the home setting. The bill would specify that nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications.~~

(2) The act authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistent with the certified nurse-midwife's educational preparation in specified facilities and clinics, and only in accordance with standardized procedures and protocols, including physician and surgeon supervision.

This bill additionally would authorize a certified nurse-midwife to furnish and order drugs and devices related to care rendered in a home and only would require physician and surgeon supervision for the furnishing and ordering of drugs and devices if the standardized procedures and protocols require supervision. The bill would authorize a certified nurse-midwife to directly procure supplies and devices, to obtain and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice and consistent with nurse-midwifery education preparation.

(3) The act also authorizes a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree

lacerations of the perineum in a licensed acute care hospital and a licensed alternative birth center, if certain requirements are met, including, but not limited to, that episiotomies are performed pursuant to protocols developed by the supervising physician and surgeon.

This bill would also authorize a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a home setting and in a birth center accredited by a national accrediting body approved by the board. The bill would delete all requirements that those procedures be performed pursuant to protocols developed and approved by the supervising physician and surgeon. The bill would require a certified nurse-midwife when performing those procedures to ensure that all complications are referred to a physician and surgeon immediately and to ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife or emergency care for times when a physician and surgeon is not available. By placing new requirements on a certified nurse-midwife, this bill would expand an existing crime and would, therefore, result in a state-mandated local program.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 2746.5 of the Business and Professions
- 2 Code is amended to read:
- 3 2746.5. (a) The certificate to practice nurse-midwifery
- 4 authorizes the holder, ~~under the supervision of a licensed physician~~
- 5 ~~and surgeon,~~ holder to attend cases of normal childbirth and to
- 6 provide prenatal, intrapartum, and postpartum care, including
- 7 family-planning care, for the mother, and immediate care for the
- 8 ~~newborn.~~ newborn in a variety of settings, including, but not limited
- 9 to, the home setting.

(b) As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, ~~under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics,~~ *person* to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician *and surgeon* immediately. The practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

(c) ~~As used in this article, “supervision” shall not be construed to require the physical presence of the supervising physician. A certified nurse-midwife may consult, refer, or transfer care to a physician and surgeon as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. Nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications.~~

(d) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

(e) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board.

SEC. 2. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other ~~provision of~~ law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

(1) The drugs or devices are furnished or ordered ~~incidentally~~ *related* to the provision of any of the following:

(A) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(B) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(C) Care rendered, consistent with the certified nurse-midwife’s educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the

1 Health and Safety Code, a clinic as specified in Section 1204 of
2 the Health and Safety Code, a general acute care hospital as defined
3 in subdivision (a) of Section 1250 of the Health and Safety Code,
4 a licensed birth center as defined in Section 1204.3 of the Health
5 and Safety Code, or a special hospital specified as a maternity
6 hospital in subdivision (f) of Section 1250 of the Health and Safety
7 Code.

8 *(D) Care rendered in a home pursuant to subdivision (a) of*
9 *Section 2746.5.*

10 (2) The drugs or devices are furnished or ordered by a certified
11 nurse-midwife in accordance with standardized procedures or
12 protocols. For purposes of this section, standardized procedure
13 means a document, including protocols, developed and approved
14 by ~~the supervising~~ a physician and surgeon, the certified
15 nurse-midwife, and the facility administrator or his or her designee.
16 The standardized procedure covering the furnishing or ordering
17 of drugs or devices shall specify all of the following:

18 (A) Which certified nurse-midwife may furnish or order drugs
19 or devices.

20 (B) Which drugs or devices may be furnished or ordered and
21 under what circumstances.

22 (C) The extent of physician and surgeon ~~supervision~~. *supervision*
23 *required, if any.*

24 (D) The method of periodic review of the certified
25 nurse-midwife's competence, including peer review, and review
26 of the provisions of the standardized procedure.

27 (3) If Schedule II or III controlled substances, as defined in
28 Sections 11055 and 11056 of the Health and Safety Code, are
29 furnished or ordered by a certified nurse-midwife, the controlled
30 substances shall be furnished or ordered in accordance with a
31 patient-specific protocol approved by the treating ~~or supervising~~
32 physician and surgeon. For Schedule II controlled substance
33 protocols, the provision for furnishing the Schedule II controlled
34 substance shall address the diagnosis of the illness, injury, or
35 condition for which the Schedule II controlled substance is to be
36 furnished.

37 (4) The furnishing or ordering of drugs or devices by a certified
38 nurse-midwife occurs under ~~physician and surgeon supervision~~.
39 ~~For purposes of this section, no physician and surgeon shall~~
40 ~~supervise more than four certified nurse-midwives at one time.~~

1 ~~Physician~~ *standardized procedures and protocols. If the*
2 *standardized procedures and protocols require physician and*
3 *surgeon supervision*, supervision shall not be construed to require
4 the physical presence of the physician, but does include all of the
5 following:

6 (A) Collaboration on the development of the standardized
7 procedure or protocol.

8 (B) Approval of the standardized procedure or protocol.

9 (C) Availability by telephonic contact at the time of patient
10 examination by the certified nurse-midwife.

11 (b) (1) The furnishing or ordering of drugs or devices by a
12 certified nurse-midwife is conditional on the issuance by the board
13 of a number to the applicant who has successfully completed the
14 requirements of paragraph (2). The number shall be included on
15 all transmittals of orders for drugs or devices by the certified
16 nurse-midwife. The board shall maintain a list of the certified
17 nurse-midwives that it has certified pursuant to this paragraph and
18 the number it has issued to each one. The board shall make the list
19 available to the California State Board of Pharmacy upon its
20 request. Every certified nurse-midwife who is authorized pursuant
21 to this section to furnish or issue a drug order for a controlled
22 substance shall register with the United States Drug Enforcement
23 Administration.

24 (2) The board has certified in accordance with paragraph (1)
25 that the certified nurse-midwife has satisfactorily completed a
26 course in pharmacology covering the drugs or devices to be
27 furnished or ordered under this section. The board shall establish
28 the requirements for satisfactory completion of this paragraph.

29 (3) A physician and surgeon may determine the extent of
30 supervision necessary pursuant to this section in the furnishing or
31 ordering of drugs and devices.

32 (4) A copy of the standardized procedure or protocol relating
33 to the furnishing or ordering of controlled substances by a certified
34 nurse-midwife shall be provided upon request to any licensed
35 pharmacist who is uncertain of the authority of the certified
36 nurse-midwife to perform these functions.

37 (5) Certified nurse-midwives who are certified by the board
38 and hold an active furnishing number, who are currently authorized
39 through standardized procedures or protocols to furnish Schedule
40 II controlled substances, and who are registered with the United

1 States Drug Enforcement Administration shall provide
2 documentation of continuing education specific to the use of
3 Schedule II controlled substances in settings other than a hospital
4 based on standards developed by the board.

5 (c) Drugs or devices furnished or ordered by a certified
6 nurse-midwife may include Schedule II controlled substances
7 under the California Uniform Controlled Substances Act (Division
8 10 (commencing with Section 11000) of the Health and Safety
9 Code) under the following conditions:

10 (1) The drugs and devices are furnished or ordered in accordance
11 with requirements referenced in paragraphs (2) to (4), inclusive,
12 of subdivision (a) and in paragraphs (1) to (3), inclusive, of
13 subdivision (b).

14 (2) When Schedule II controlled substances, as defined in
15 Section 11055 of the Health and Safety Code, are furnished or
16 ordered by a certified nurse-midwife, the controlled substances
17 shall be furnished or ordered in accordance with a patient-specific
18 protocol approved by ~~the treating or supervising~~ a physician and
19 surgeon.

20 (d) Furnishing of drugs or devices by a certified nurse-midwife
21 means the act of making a pharmaceutical agent or agents available
22 to the patient in strict accordance with a standardized procedure
23 or protocol. Use of the term “furnishing” in this section ~~shall~~
24 ~~include the following:~~ *includes*

25 ~~(1) The~~ *the* ordering of a drug or device in accordance with the
26 standardized procedure or protocol.

27 ~~(2) Transmitting an order of a supervising physician and~~
28 ~~surgeon.~~

29 (e) “Drug order” or “order” for purposes of this section means
30 an order for medication or for a drug or device that is dispensed
31 to or for an ultimate user, issued by a certified nurse-midwife as
32 an individual practitioner, within the meaning of Section 1306.03
33 of Title 21 of the Code of Federal Regulations. Notwithstanding
34 any other ~~provision of law~~, (1) a drug order issued pursuant to this
35 section shall be treated in the same manner as a prescription of the
36 ~~supervising~~ a physician; (2) all references to “prescription” in this
37 code and the Health and Safety Code shall include drug orders
38 issued by certified nurse-midwives; and (3) the signature of a
39 certified nurse-midwife on a drug order issued in accordance with

1 this section shall be deemed to be the signature of a prescriber for
2 purposes of this code and the Health and Safety Code.

3 (f) *Notwithstanding any other law, a certified nurse-midwife is*
4 *authorized to directly procure supplies and devices, to obtain and*
5 *administer drugs and diagnostic tests, to order laboratory and*
6 *diagnostic testing, and to receive reports that are necessary to his*
7 *or her practice as a certified nurse-midwife and consistent with*
8 *nurse-midwifery education preparation.*

9 SEC. 3. Section 2746.52 of the Business and Professions Code
10 is amended to read:

11 2746.52. (a) Notwithstanding Section 2746.5, the certificate
12 to practice nurse-midwifery authorizes the holder to perform and
13 repair episiotomies, and to repair first-degree and second-degree
14 lacerations of the perineum, in a licensed acute care hospital, as
15 defined in subdivision (a) of Section 1250 of the Health and Safety
16 Code, ~~and a licensed alternate~~ *alternative* birth center, as defined
17 in paragraph (4) of subdivision (b) of Section 1204 of the Health
18 and Safety Code, ~~but only if all of the following conditions are~~
19 ~~met:~~ *a birth center accredited by a national accrediting body*
20 *approved by the board, and in a home setting.*

21 ~~(a) The supervising physician and surgeon and any backup~~
22 ~~physician and surgeon is credentialed to perform obstetrical care~~
23 ~~in the facility.~~

24 ~~(b) The episiotomies are performed pursuant to protocols~~
25 ~~developed and approved by all of the following:~~

26 ~~(1) The supervising physician and surgeon.~~

27 ~~(2) The certified nurse-midwife.~~

28 ~~(3) The director of the obstetrics department or the director of~~
29 ~~the family practice department, or both, if a physician and surgeon~~
30 ~~in the obstetrics department or the family practice department is~~
31 ~~a supervising physician and surgeon, or an equivalent person if~~
32 ~~there is no specifically identified obstetrics department or family~~
33 ~~practice department.~~

34 ~~(4) The interdisciplinary practices committee, if applicable.~~

35 ~~(5) The facility administrator or his or her designee.~~

36 ~~(e) The protocols, and the procedures which shall be developed~~
37 ~~pursuant to the protocols, shall relate to the performance and repair~~
38 ~~of episiotomies and the repair of first-degree and second-degree~~
39 ~~lacerations of the perineum, and shall do all of the following:~~

1 (b) A certified nurse-midwife performing and repairing
2 episiotomies and repairing first-degree and second-degree
3 lacerations of the perineum, shall do both of the following:

4 (1) Ensure that all complications are referred to a physician and
5 surgeon immediately.

6 (2) Ensure immediate care of patients who are in need of care
7 beyond the scope of practice of the certified ~~nurse-midwife~~;
8 *nurse-midwife*, or emergency care for times when ~~the supervising~~
9 *a physician and surgeon is not on the premises*; *available*.

10 ~~(3) Establish the number of certified nurse-midwives that a~~
11 ~~supervising physician and surgeon may supervise.~~

12 SEC. 4. *No reimbursement is required by this act pursuant to*
13 *Section 6 of Article XIII B of the California Constitution because*
14 *the only costs that may be incurred by a local agency or school*
15 *district will be incurred because this act creates a new crime or*
16 *infraction, eliminates a crime or infraction, or changes the penalty*
17 *for a crime or infraction, within the meaning of Section 17556 of*
18 *the Government Code, or changes the definition of a crime within*
19 *the meaning of Section 6 of Article XIII B of the California*
20 *Constitution.*

21 SECTION 1. ~~Section 2746.2 of the Business and Professions~~
22 ~~Code is amended to read:~~

23 ~~2746.2. Each applicant shall show by evidence satisfactory to~~
24 ~~the board that he or she has met the educational standards~~
25 ~~established by the board or has at least the equivalent thereof,~~
26 ~~including evidence of current advanced level national certification~~
27 ~~by a certifying body that meets standards established and approved~~
28 ~~by the board. The board is authorized to appoint a committee of~~
29 ~~qualified physicians and nurses, including, but not limited to,~~
30 ~~obstetricians and nurse-midwives, to develop the necessary~~
31 ~~standards relating to educational requirements and associated~~
32 ~~matters.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1650
Author: Maienschein
Bill Date: April 20, 2017, Amended
Subject: Emergency Medical Services: Community Paramedicine
Sponsor: California Ambulance Association
Position: Oppose

DESCRIPTION OF LEGISLATION:

This bill would create the Community Paramedic Program (Program) in the Emergency Medical Services Authority (EMSA). This bill would sunset the Program on January 1, 2022.

BACKGROUND

Under existing law, a paramedic is limited to providing care in emergency situations, during ambulance transports, and while working in a hospital. Beginning in late 2014, thirteen community paramedicine pilot projects began in California, testing six concepts as part of the Health Workforce Pilot Project (HWPP) #173. These HWPP pilot projects are coordinated through the Office of Statewide Health Planning and Development (OSHPD). This bill would authorize four of the original six concepts allowed for in the pilot project.

ANALYSIS

This bill would allow the Program to authorize a local emergency medical services (EMS) agency that opts to participate in the Program to provide, through a local community paramedic program, any of the following services:

- Post-discharge follow up services for targeted and eligible patients recently discharged from a hospital participating in the Program, which is intended to provide short-term assistance in order to reduce hospital admission and shall not replace home health care or any other services available.
- Directly observed therapy for eligible patients undergoing tuberculosis treatment in partnership with a county public health department. This therapy service is intended as a supplement to provide for after-hours availability or to reach patients who are difficult to serve, and shall not replace community health workers or public health nurses.
- Hospice rapid response service for eligible and enrolled patients to administer comfort care, coordinate services with the hospice nurse, and, as appropriate, avoid patient transport to an acute care hospital emergency department.
- Case management services and linkage to non-emergency services for frequent EMS system users, for the purpose of reducing dependence of those users on the EMS system and acute care hospital emergency departments to provide primary medical care.

This bill would require EMSA to develop criteria that qualifies local community paramedic services to participate in the Program. The criteria must include minimum training and certification requirements for a community paramedic, including, but not limited to, the following:

- Four years of job experience as an EMT-P.
- At least 48 hours of classroom-based instruction.
- At least four hours of clinical, hands-on training.
- At least 56 hours of study outside the classroom.

EMSA would also be required to develop regulations for the initiation, operation, and evaluation of a local community paramedic program. This bill would require EMSA to develop an application and application process to be used by a local EMS agency that seeks to participate in the Program and to review and approve these applications. EMSA would be required to consult with OSHPD on the implementation of this Program. This bill would require EMSA to provide OSHPD with an annual report regarding all local community paramedic programs that shall include, but not be limited to, information regarding program effectiveness, cost-savings, and patient safety, including details regarding any adverse patient outcomes. OSHPD would be required to publish the report on its website.

This bill would specify that a local EMS agency can opt to participate in the Program as long as they meet the criteria and submit an application to EMSA. This bill would require a community paramedic service plan developed by a local EMS agency that seeks to participate in the Program to demonstrate it will be able to meet all the requirements of the Program and include specified information.

This bill would sunset the Program on January 1, 2022.

According to the author, a report published in January 2017 concluded that the HWPP pilot projects resulted in improved health care for the targeted patients, as well as a reduction in health care costs. The intent of this bill, according to the author, is to permanently authorize the expanded role of paramedics and to establish parameters for community paramedicine programs.

Board staff, working with a Board Member who is a physician, provided input to OSHPD on HWPP #173 and raised patient safety concerns. One of these concerns being that persons recently discharged from the hospital should be seen by their primary care physician for follow up care. The additional training that would be required would not be sufficient enough to teach paramedics the basics of disease management or how to diagnose and treat medical conditions. The other concern raised was that the pilot project did not specifically delineate what services will be allowed to be performed by community paramedics as part of the post-discharge follow up services and case management services; the same is true for this bill. This bill could have a negative impact on consumer protection; as such, the Board opposes this bill.

FISCAL: None

SUPPORT: California Ambulance Association (Sponsor)
California Hospital Association
County Behavioral Health Director's Association
Assisted Hospice Care

OPPOSITION: American College of Emergency Physicians (Unless Amended)
California Association for Health Services at Home
California Hospice and Palliative Care Association
California Nurses Association/National Nurses Association
Medical Board of California

AMENDED IN ASSEMBLY APRIL 20, 2017

AMENDED IN ASSEMBLY APRIL 6, 2017

AMENDED IN ASSEMBLY MARCH 29, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL

No. 1650

Introduced by Assembly Member Maienschein
(Coauthors: Assembly Members Chávez and Mathis)
(Coauthor: Senator Wilk)

February 17, 2017

An act to add *and repeal* Chapter 13 (commencing with Section 1800) ~~to~~ of Division 2.5 of the Health and Safety Code, relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1650, as amended, Maienschein. Emergency medical services: community paramedicine.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state agencies concerning emergency medical services. Among other duties, the authority is required to develop planning and implementation guidelines for emergency medical services systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems, and receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.

This bill ~~would~~ *would, until January 1, 2022,* create the Community Paramedic Program in the authority. The bill would authorize the authority to authorize a local EMS agency that opts to participate in the program to provide specified services, such as case management services and linkage to nonemergency services for frequent EMS system users, through a local community paramedic program. The bill would require the authority, in consultation with the Office of Statewide Health Planning and Development, to develop criteria to qualify services for participation in the program, develop an application and application process for local EMS agencies seeking to participate in the program, and to review and approve applications for participation in the program as a component of the local EMS agency's EMS plan. The bill would authorize a local EMS agency to opt to participate in the program if it meets the criteria established by the authority and completes the application process developed by the criteria. The bill would specify the necessary components of a community paramedic service plan to be included in the local EMS agency's application. The bill would require the medical director of the local EMS agency to oversee the local community paramedic program. *The bill would require the authority to annually report specified information related to local community paramedic programs to the office, and require the office to publish the report on its Internet Web site.*

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Chapter 13 (commencing with Section 1800) is
2 added to Division 2.5 of the Health and Safety Code, to read:

3
4 CHAPTER 13. COMMUNITY PARAMEDIC PROGRAM

5
6 Article 1. General Provisions

7
8 1800. This chapter shall be known, and may be cited, as the
9 Community Paramedic Program Act.

10 1802. Unless the context requires otherwise, the following
11 definitions shall apply to this chapter:

12 (a) "Community paramedic" means an individual who is
13 educated and trained in community paramedicine, whose scope of

1 practice is in accordance with standards established by the
2 authority, who holds a current certification as a mobile integrated
3 health community paramedic by the International Board of
4 Specialty Certification or equivalent, who has a valid license issued
5 pursuant to this chapter, and who is accredited by a local EMS
6 agency.

7 (b) "Program" means the Community Paramedic Program
8 established by this chapter.

9 1804. Within the authority there is the statewide Community
10 Paramedic Program. The program may authorize a local EMS
11 agency that opts to participate in the program to provide, through
12 a local community paramedic program, *and notwithstanding*
13 *Sections 1797.52 and 1797.218*, any of the following services:

14 (a) (1) Postdischarge followup services for targeted and eligible
15 patients recently discharged from a hospital participating in the
16 program.

17 (2) A postdischarge service authorized pursuant to this
18 subdivision is intended to provide short-term assistance in order
19 to reduce hospital admissions and shall not replace home health
20 care or any other services available to patients.

21 (b) (1) Directly observed therapy for eligible patients
22 undergoing tuberculosis treatment in partnership with a county
23 public health department.

24 (2) A directly observed therapy service authorized pursuant to
25 this subdivision is intended as a supplement to provide for
26 after-hours availability or to reach patients who are difficult to
27 serve, and shall not replace home community health workers or
28 public health nurses.

29 (c) Hospice rapid response service for eligible and enrolled
30 patients to administer comfort care, coordinate services with the
31 hospice nurse, and, as appropriate, avoid patient transport to an
32 acute care hospital emergency department.

33 (d) Case management services and linkage to nonemergency
34 services for frequent EMS system users, for the purpose of reducing
35 dependence of those users on the EMS system and acute care
36 hospital emergency departments to provide primary medical care.

Article 2. Duties and Powers of the Authority

1810. (a) To implement the program, the authority shall do all of the following:

(1) Develop criteria that qualify local community paramedic services to participate in the program.

(2) Develop an application and application process to be used by a local EMS agency that seeks to participate in the program. The application process shall provide for the submission of a local community paramedic service plan described in Section 1820 that shall be a component of the local EMS agency's local EMS plan.

(3) Review and approve applications for the implementation of local community paramedic services as a component of the local EMS agency's EMS plan in accordance with Section 1797.105.

(b) Criteria described in paragraph (1) of subdivision (a) shall include, but not be limited to, the following:

~~(1) Training—~~*Minimum training and certification requirements for a community paramedic, including, but not limited to, the following:*

(A) Four years of job experience as an EMT-P.

(B) At least 48 hours of classroom-based instruction.

(C) At least four hours of clinical, hands-on training.

(D) At least 56 hours of study outside of the classroom.

(2) Regulations for the initiation, operation, and evaluation of a local community paramedic program.

1812. (a) The authority shall consult with the Office of Statewide Health Planning and Development in performing its duties required by this chapter.

(b) The authority shall provide the Office of Statewide Health Planning and Development with an annual report regarding all local community paramedic programs that shall include, but not be limited to, information regarding program effectiveness, cost-savings, and patient safety, including details regarding any adverse patient outcomes. The Office of Statewide Health Planning and Development shall publish the report on its Internet Web site.

Article 3. Local EMS Agency Participation

1820. (a) A local EMS agency may opt to participate in the program by meeting the criteria and completing the application

1 and application process established by the authority pursuant to
2 Section 1810.

3 (b) A community paramedic service plan developed by a local
4 EMS agency that seeks to participate in the program shall
5 demonstrate that the local EMS agency will be able to meet the
6 requirements of the program and shall include, but not be limited
7 to, all of the following:

8 (1) Agreements between local agencies and service providers
9 participating or partnering in the local community paramedic
10 program.

11 (2) A description of the local community paramedic program.

12 (3) A description of existing problems that the local community
13 paramedic program is intended to address.

14 (4) Criteria for the enrollment or inclusion of patients in the
15 local community paramedic program.

16 (5) Goals and intended results of the local community paramedic
17 program.

18 (6) Criteria for patient and provider safety.

19 (7) Estimated costs and savings attributable to the local
20 community paramedic program.

21 (8) Data to be collected for the purpose of evaluating the
22 effectiveness of the local community paramedic program.

23 (9) Criteria and processes for evaluating the effectiveness of
24 the local community paramedic program.

25 (10) Protocols, policies, and procedures for the implementation
26 and operation of local community paramedic program services by
27 a community paramedic.

28 (11) Protocols for the assessment of patients served by the local
29 community paramedic program.

30 (12) Any other information or plan component required by the
31 authority pursuant to Section 1810.

32 1822. The local EMS agency medical director shall oversee a
33 local community paramedic program participating in the program.

34 1823. *This chapter shall remain in effect only until January 1,*
35 *2022, and as of that date is repealed, unless a later enacted statute*
36 *that is enacted before January 1, 2022, deletes or extends that*
37 *date.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 241
Author: Monning
Bill Date: February 6, 2017, Introduced
Subject: Medical Records: Access
Sponsor: Author
Position: Support

DESCRIPTION OF LEGISLATION:

This bill would revise existing law regarding the rights of patients to access and copy their medical records.

BACKGROUND

Existing law, the Patient Access to Health Records (PAHR) law, specifies that any adult patient of a health care provider, or any minor patient authorized by law to consent to medical treatment, or any patient representative, is entitled to inspect patient records upon presenting a health care provider with a written request for those records and upon payment of reasonable clerical costs incurred in locating and making those records available.

Existing law establishes the federal Health Information Portability and Accountability Act of 1996 (HIPAA), which provides federal protections for patients' health information held by "covered entities" and any "business associates" that a covered entity engages to help it carry out its health care activities. A covered entity can be a provider, a health plan, or a health care clearinghouse that processes health information it receives from another entity. While HIPAA establishes a federal baseline for minimum privacy protections of individually identifiable health information, states are permitted to enact laws that provide greater privacy protections or rights.

ANALYSIS

This bill would conform existing PAHR law to HIPAA and would describe what costs a health care provider could charge patients or their representative for medical records. This bill would also repeal the requirement in existing law that requests by patients for their records be "written" requests. This bill would clarify that a patient or patient representative is entitled to a paper or electronic copy of their records.

This bill would conform existing PAHR law to HIPAA, as it would require a health care provider, if the requested patient records are maintained electronically and if the patient or their representative requests an electronic copy of those records, to provide them in the electronic format requested if they are readily producible in that format, or, if not, in a readable electronic format as agreed to by the health care provider and the patient or their representative.

This bill would revise existing PAHR law and conform it with HIPAA relating to what a health care provider can charge a patient or their representative and would allow a health care provider to impose a reasonable cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee only includes the cost of the following:

- Labor for copying the patient records requested by the patient or their representative, whether in paper or electronic form.
- Supplies for creating the paper copy or electronic media if the patient or their representative requests that the electronic copy be provided on portable media.
- Postage, if the patient or their representative has requested the copy, or the summary or explanation, be mailed.
- Time for preparing an explanation or summary of the patient's record, if agreed to by the patient or their representative.

This bill would retain the existing maximum limit cost for copies at 25 cents per page or 50 cents per page for copies from microfilm.

According to the author, patients and their representatives have rights to access their medical records, and these rights need to be understandable if they are to be exercised and followed. The purpose for access to medical records includes tracking care between different health care providers and verifying accurate records. Because of differences with federal law, this bill seeks to align and better clarify state law in areas where federal law preempts or is more detailed. The author believes these changes will reduce confusion among patients and providers and may allow for better adherence to laws among all health care providers.

This bill would conform existing PAHR law to HIPAA and update the law to allow for electronic requests for patient records and would allow patients and their representatives to receive electronic copies of those records. This bill would also make it clear that any fee imposed must be reasonable and cost-based, which may help to clarify what actual costs can be charged. This bill would also help ensure that patients have better access to their medical records. As such, the Board took a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Health Facilities
California Hospital Association
Medical Board of California
Western Center on Law and Poverty

OPPOSITION: None on file

Introduced by Senator Monning

February 6, 2017

An act to amend Section 123110 of the Health and Safety Code, and to amend Section 5328 of the Welfare and Institutions Code, relating to medical records.

LEGISLATIVE COUNSEL'S DIGEST

SB 241, as introduced, Monning. Medical records: access.

Existing law governs a patient's access to his or her health records. Existing law requires a health care provider to provide a patient or his or her representative with all or any part of the patient's medical records that the patient has a right to inspect, subject to the payment of clerical costs incurred in locating and making the records available, following a written request from the patient. If the patient or patient's representative presents proof to the provider that the records are needed to support an appeal regarding eligibility for a public benefit program, as defined, the health care provider must provide one copy of the relevant portion of the patient's record at no charge under specified circumstances. Existing law makes a violation of these provisions by specified health care providers an infraction.

This bill would change the basis of the fee that a health care provider is authorized to charge from clerical costs to specified costs for labor, supplies, postage, and preparing an explanation or summary of the patient record. The bill would require the health care provider to provide the patient or patient's personal representative with a copy of the records in a paper or electronic copy, in the form or format requested if the records are readily producible in that form or format.

Existing law provides that information and records obtained in the course of providing mental health and developmental services are

confidential, but allows disclosure of communications under specified circumstances.

This bill would allow disclosure to a business associate or for health care operations purposes, as specified.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 123110 of the Health and Safety Code
2 is amended to read:

3 123110. (a) Notwithstanding Section 5328 of the Welfare and
4 Institutions Code, and except as provided in Sections 123115 and
5 123120, any adult patient of a health care provider, any minor
6 patient authorized by law to consent to medical treatment, and any
7 patient *personal* representative shall be entitled to inspect patient
8 records upon presenting to the health care provider a ~~written~~ request
9 for those records and upon payment of reasonable ~~clerical costs~~
10 ~~incurred in locating and making the records available. costs as~~
11 ~~specified in subdivision (k).~~ However, a patient who is a minor
12 shall be entitled to inspect patient records pertaining only to health
13 care of a type for which the minor is lawfully authorized to consent.
14 A health care provider shall permit this inspection during business
15 hours within five working days after receipt of the ~~written~~ request.
16 The inspection shall be conducted by the patient or patient's
17 *personal* representative requesting the inspection, who may be
18 accompanied by one other person of his or her choosing.

19 (b) (1) Additionally, any patient or patient's *personal*
20 representative shall be entitled to ~~copies a paper or electronic copy~~
21 of all or any portion of the patient records that he or she has a right
22 to inspect, upon presenting a ~~written~~ request to the health care
23 provider specifying the records to be copied, together with a fee
24 to defray the ~~cost of copying, that shall not exceed twenty-five~~
25 ~~cents (\$0.25) per page or fifty cents (\$0.50) per page for records~~
26 ~~that are copied from microfilm and any additional reasonable~~

1 ~~clerical costs incurred in making the records available; costs of~~
2 ~~producing the copy or summary, as specified in subdivision (k).~~
3 The health care provider shall ensure that the copies are transmitted
4 within 15 days after receiving the ~~written~~ request.

5 (2) *The health care provider shall provide the patient or*
6 *patient's personal representative with a copy of the record in the*
7 *form and format requested if it is readily producible in the*
8 *requested form and format, or, if not, in a readable paper copy*
9 *form or other form and format as agreed to by the health care*
10 *provider and the patient or patient's personal representative. If*
11 *the requested patient records are maintained electronically and*
12 *if the patient or patient's personal representative requests an*
13 *electronic copy of those records, the health care provider shall*
14 *provide them in the electronic form and format requested if they*
15 *are readily producible in that form and format, or, if not, in a*
16 *readable electronic form and format as agreed to by the health*
17 *care provider and the patient or patient's personal representative.*

18 (c) Copies of X-rays or tracings derived from
19 electrocardiography, electroencephalography, or electromyography
20 need not be provided to the patient or patient's *personal*
21 representative under this section, if the original X-rays or tracings
22 are transmitted to another health care provider upon written request
23 of the patient or patient's *personal* representative and within 15
24 days after receipt of the request. The request shall specify the name
25 and address of the health care provider to whom the records are
26 to be delivered. All reasonable costs, not exceeding actual costs,
27 incurred by a health care provider in providing copies pursuant to
28 this subdivision may be charged to the patient or representative
29 requesting the copies.

30 (d) (1) Notwithstanding any provision of this section, and
31 except as provided in Sections 123115 and 123120, any patient or
32 former patient or the patient's *personal* representative shall be
33 entitled to a copy, at no charge, of the relevant portion of the
34 patient's records, upon presenting to the provider a written request,
35 and proof that the records are needed to support an appeal regarding
36 eligibility for a public benefit program. These programs shall be
37 the Medi-Cal program, social security disability insurance benefits,
38 and Supplemental Security Income/State Supplementary Program
39 for the Aged, Blind and Disabled (SSI/SSP) benefits. For purposes
40 of this subdivision, "relevant portion of the patient's records"

1 means those records regarding services rendered to the patient
2 during the time period beginning with the date of the patient's
3 initial application for public benefits up to and including the date
4 that a final determination is made by the public benefits program
5 with which the patient's application is pending.

6 (2) Although a patient shall not be limited to a single request,
7 the patient or patient's *personal* representative shall be entitled to
8 no more than one copy of any relevant portion of his or her record
9 free of charge.

10 (3) This subdivision shall not apply to any patient who is
11 represented by a private attorney who is paying for the costs related
12 to the patient's appeal, pending the outcome of that appeal. For
13 purposes of this subdivision, "private attorney" means any attorney
14 not employed by a nonprofit legal services entity.

15 (e) If the patient's appeal regarding eligibility for a public
16 benefit program specified in subdivision (d) is successful, the
17 hospital or other health care provider may bill the patient, at the
18 rates specified in subdivisions (b) and (c), for the copies of the
19 medical records previously provided free of charge.

20 (f) If a patient or his or her *personal* representative requests a
21 record pursuant to subdivision (d), the health care provider shall
22 ensure that the copies are transmitted within 30 days after receiving
23 the written request.

24 (g) This section shall not be construed to preclude a health care
25 provider from requiring reasonable verification of identity prior
26 to permitting inspection or copying of patient records, provided
27 this requirement is not used oppressively or discriminatorily to
28 frustrate or delay compliance with this section. Nothing in this
29 chapter shall be deemed to supersede any rights that a patient or
30 *personal* representative might otherwise have or exercise under
31 Section 1158 of the Evidence Code or any other provision of law.
32 Nothing in this chapter shall require a health care provider to retain
33 records longer than required by applicable statutes or administrative
34 regulations.

35 (h) This chapter shall not be construed to render a health care
36 provider liable for the quality of his or her records or the copies
37 provided in excess of existing law and regulations with respect to
38 the quality of medical records. A health care provider shall not be
39 liable to the patient or any other person for any consequences that
40 result from disclosure of patient records as required by this chapter.

1 A health care provider shall not discriminate against classes or
2 categories of providers in the transmittal of X-rays or other patient
3 records, or copies of these X-rays or records, to other providers as
4 authorized by this section.

5 Every health care provider shall adopt policies and establish
6 procedures for the uniform transmittal of X-rays and other patient
7 records that effectively prevent the discrimination described in
8 this subdivision. A health care provider may establish reasonable
9 conditions, including a reasonable deposit fee, to ensure the return
10 of original X-rays transmitted to another health care provider,
11 provided the conditions do not discriminate on the basis of, or in
12 a manner related to, the license of the provider to which the X-rays
13 are transmitted.

14 (i) Any health care provider described in paragraphs (4) to (10),
15 inclusive, of subdivision (a) of Section 123105 who willfully
16 violates this chapter is guilty of unprofessional conduct. Any health
17 care provider described in paragraphs (1) to (3), inclusive, of
18 subdivision (a) of Section 123105 that willfully violates this chapter
19 is guilty of an infraction punishable by a fine of not more than one
20 hundred dollars (\$100). The state agency, board, or commission
21 that issued the health care provider's professional or institutional
22 license shall consider a violation as grounds for disciplinary action
23 with respect to the licensure, including suspension or revocation
24 of the license or certificate.

25 (j) This section shall be construed as prohibiting a health care
26 provider from withholding patient records or summaries of patient
27 records because of an unpaid bill for health care services. Any
28 health care provider who willfully withholds patient records or
29 summaries of patient records because of an unpaid bill for health
30 care services shall be subject to the sanctions specified in
31 subdivision (i).

32 (k) (1) *Except as provided in subdivision (d), a health care*
33 *provider may impose a reasonable, cost-based fee for providing*
34 *a paper or electronic copy or summary of patient records, provided*
35 *the fee includes only the cost of the following:*

36 (A) *Labor for copying the patient records requested by the*
37 *patient or patient's personal representative, whether in paper or*
38 *electronic form.*

1 (B) *Supplies for creating the paper copy or electronic media if*
2 *the patient or patient's personal representative requests that the*
3 *electronic copy be provided on portable media.*

4 (C) *Postage, if the patient or patient's personal representative*
5 *has requested the copy, or the summary or explanation, be mailed.*

6 (D) *Preparing an explanation or summary of the patient record,*
7 *if agreed to by the patient or patient's personal representative.*

8 (2) *The fee from a health care provider shall not exceed*
9 *twenty-five cents (\$0.25) per page for paper copies or fifty cents*
10 *(\$0.50) per page for records that are copied from microfilm.*

11 SEC. 2. Section 5328 of the Welfare and Institutions Code is
12 amended to read:

13 5328. All information and records obtained in the course of
14 providing services under Division 4 (commencing with Section
15 4000), Division 4.1 (commencing with Section 4400), Division
16 4.5 (commencing with Section 4500), Division 5 (commencing
17 with Section 5000), Division 6 (commencing with Section 6000),
18 or Division 7 (commencing with Section 7100), to either voluntary
19 or involuntary recipients of services shall be confidential.
20 Information and records obtained in the course of providing similar
21 services to either voluntary or involuntary recipients prior to 1969
22 shall also be confidential. Information and records shall be
23 disclosed only in any of the following cases:

24 (a) In communications between qualified professional persons
25 in the provision of services or appropriate referrals, or in the course
26 of conservatorship proceedings. The consent of the patient, or his
27 or her guardian or conservator, shall be obtained before information
28 or records may be disclosed by a professional person employed
29 by a facility to a professional person not employed by the facility
30 who does not have the medical or psychological responsibility for
31 the patient's care.

32 (b) When the patient, with the approval of the physician and
33 surgeon, licensed psychologist, social worker with a master's
34 degree in social work, licensed marriage and family therapist, or
35 licensed professional clinical counselor, who is in charge of the
36 patient, designates persons to whom information or records may
37 be released, except that nothing in this article shall be construed
38 to compel a physician and surgeon, licensed psychologist, social
39 worker with a master's degree in social work, licensed marriage
40 and family therapist, licensed professional clinical counselor, nurse,

1 attorney, or other professional person to reveal information that
2 has been given to him or her in confidence by members of a
3 patient's family. Nothing in this subdivision shall be construed to
4 authorize a licensed marriage and family therapist or licensed
5 professional clinical counselor to provide services or to be in charge
6 of a patient's care beyond his or her lawful scope of practice.

7 (c) To the extent necessary for a recipient to make a claim, or
8 for a claim to be made on behalf of a recipient for aid, insurance,
9 or medical assistance to which he or she may be entitled.

10 (d) If the recipient of services is a minor, ward, dependent, or
11 conservatee, and his or her parent, guardian, guardian ad litem,
12 conservator, or authorized representative designates, in writing,
13 persons to whom records or information may be disclosed, except
14 that nothing in this article shall be construed to compel a physician
15 and surgeon, licensed psychologist, social worker with a master's
16 degree in social work, licensed marriage and family therapist,
17 licensed professional clinical counselor, nurse, attorney, or other
18 professional person to reveal information that has been given to
19 him or her in confidence by members of a patient's family.

20 (e) For research, provided that the Director of Health Care
21 Services, the Director of State Hospitals, the Director of Social
22 Services, or the Director of Developmental Services designates
23 by regulation, rules for the conduct of research and requires the
24 research to be first reviewed by the appropriate institutional review
25 board or boards. The rules shall include, but need not be limited
26 to, the requirement that all researchers shall sign an oath of
27 confidentiality as follows:

28
29 _____
30 Date
31

32 As a condition of doing research concerning persons who have
33 received services from ____ (fill in the facility, agency or person),
34 I, ____, agree to obtain the prior informed consent of such persons
35 who have received services to the maximum degree possible as
36 determined by the appropriate institutional review board or boards
37 for protection of human subjects reviewing my research, and I
38 further agree not to divulge any information obtained in the course
39 of such research to unauthorized persons, and not to publish or
40 otherwise make public any information regarding persons who

1 have received services such that the person who received services
2 is identifiable.

3 I recognize that the unauthorized release of confidential
4 information may make me subject to a civil action under provisions
5 of the Welfare and Institutions Code.

6
7 (f) To the courts, as necessary to the administration of justice.

8 (g) To governmental law enforcement agencies as needed for
9 the protection of federal and state elective constitutional officers
10 and their families.

11 (h) To the Senate Committee on Rules or the Assembly
12 Committee on Rules for the purposes of legislative investigation
13 authorized by the committee.

14 (i) If the recipient of services who applies for life or disability
15 insurance designates in writing the insurer to which records or
16 information may be disclosed.

17 (j) To the attorney for the patient in any and all proceedings
18 upon presentation of a release of information signed by the patient,
19 except that when the patient is unable to sign the release, the staff
20 of the facility, upon satisfying itself of the identity of the attorney,
21 and of the fact that the attorney does represent the interests of the
22 patient, may release all information and records relating to the
23 patient except that nothing in this article shall be construed to
24 compel a physician and surgeon, licensed psychologist, social
25 worker with a master's degree in social work, licensed marriage
26 and family therapist, licensed professional clinical counselor, nurse,
27 attorney, or other professional person to reveal information that
28 has been given to him or her in confidence by members of a
29 patient's family.

30 (k) Upon written agreement by a person previously confined in
31 or otherwise treated by a facility, the professional person in charge
32 of the facility or his or her designee may release any information,
33 except information that has been given in confidence by members
34 of the person's family, requested by a probation officer charged
35 with the evaluation of the person after his or her conviction of a
36 crime if the professional person in charge of the facility determines
37 that the information is relevant to the evaluation. The agreement
38 shall only be operative until sentence is passed on the crime of
39 which the person was convicted. The confidential information
40 released pursuant to this subdivision shall be transmitted to the

1 court separately from the probation report and shall not be placed
2 in the probation report. The confidential information shall remain
3 confidential except for purposes of sentencing. After sentencing,
4 the confidential information shall be sealed.

5 (l) (1) Between persons who are trained and qualified to serve
6 on multidisciplinary personnel teams pursuant to subdivision (d)
7 of Section 18951. The information and records sought to be
8 disclosed shall be relevant to the provision of child welfare services
9 or the investigation, prevention, identification, management, or
10 treatment of child abuse or neglect pursuant to Chapter 11
11 (commencing with Section 18950) of Part 6 of Division 9.
12 Information obtained pursuant to this subdivision shall not be used
13 in any criminal or delinquency proceeding. Nothing in this
14 subdivision shall prohibit evidence identical to that contained
15 within the records from being admissible in a criminal or
16 delinquency proceeding, if the evidence is derived solely from
17 means other than this subdivision, as permitted by law.

18 (2) As used in this subdivision, “child welfare services” means
19 those services that are directed at preventing child abuse or neglect.

20 (m) To county patients’ rights advocates who have been given
21 knowing voluntary authorization by a client or a guardian ad litem.
22 The client or guardian ad litem, whoever entered into the
23 agreement, may revoke the authorization at any time, either in
24 writing or by oral declaration to an approved advocate.

25 (n) To a committee established in compliance with Section
26 14725.

27 (o) In providing information as described in Section 7325.5.
28 Nothing in this subdivision shall permit the release of any
29 information other than that described in Section 7325.5.

30 (p) To the county behavioral health director or the director’s
31 designee, or to a law enforcement officer, or to the person
32 designated by a law enforcement agency, pursuant to Sections
33 5152.1 and 5250.1.

34 (q) If the patient gives his or her consent, information
35 specifically pertaining to the existence of genetically handicapping
36 conditions, as defined in Section 125135 of the Health and Safety
37 Code, may be released to qualified professional persons for
38 purposes of genetic counseling for blood relatives upon request of
39 the blood relative. For purposes of this subdivision, “qualified
40 professional persons” means those persons with the qualifications

1 necessary to carry out the genetic counseling duties under this
2 subdivision as determined by the genetic disease unit established
3 in the State Department of Health Care Services under Section
4 125000 of the Health and Safety Code. If the patient does not
5 respond or cannot respond to a request for permission to release
6 information pursuant to this subdivision after reasonable attempts
7 have been made over a two-week period to get a response, the
8 information may be released upon request of the blood relative.

9 (r) When the patient, in the opinion of his or her psychotherapist,
10 presents a serious danger of violence to a reasonably foreseeable
11 victim or victims, then any of the information or records specified
12 in this section may be released to that person or persons and to
13 law enforcement agencies and county child welfare agencies as
14 the psychotherapist determines is needed for the protection of that
15 person or persons. For purposes of this subdivision,
16 “psychotherapist” means anyone so defined within Section 1010
17 of the Evidence Code.

18 (s) (1) To the designated officer of an emergency response
19 employee, and from that designated officer to an emergency
20 response employee regarding possible exposure to HIV or AIDS,
21 but only to the extent necessary to comply with provisions of the
22 federal Ryan White Comprehensive AIDS Resources Emergency
23 Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

24 (2) For purposes of this subdivision, “designated officer” and
25 “emergency response employee” have the same meaning as these
26 terms are used in the federal Ryan White Comprehensive AIDS
27 Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C.
28 Sec. 201).

29 (3) The designated officer shall be subject to the confidentiality
30 requirements specified in Section 120980, and may be personally
31 liable for unauthorized release of any identifying information about
32 the HIV results. Further, the designated officer shall inform the
33 exposed emergency response employee that the employee is also
34 subject to the confidentiality requirements specified in Section
35 120980, and may be personally liable for unauthorized release of
36 any identifying information about the HIV test results.

37 (t) (1) To a law enforcement officer who personally lodges with
38 a facility, as defined in paragraph (2), a warrant of arrest or an
39 abstract of such a warrant showing that the person sought is wanted
40 for a serious felony, as defined in Section 1192.7 of the Penal

Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.

(B) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a person with mental illness subject to this section.

(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.

(E) A mental health rehabilitation center, as described in Section 5675.

(F) A skilled nursing facility with a special treatment program for individuals with mental illness, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(u) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to Section 15610.55, 15753.5, or 15761. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused elder or dependent adult pursuant to Chapter 13 (commencing with Section 15750) of Part 3 of Division 9.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

(x) (1) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, the following information and records may be released:

(A) All information and records that the appointing authority relied upon in issuing the notice of adverse action.

(B) All other information and records that are relevant to the adverse action, or that would constitute relevant evidence as defined in Section 210 of the Evidence Code.

(C) The information described in subparagraphs (A) and (B) may be released only if both of the following conditions are met:

(i) The appointing authority has provided written notice to the consumer and the consumer's legal representative or, if the consumer has no legal representative or if the legal representative is a state agency, to the clients' rights advocate, and the consumer, the consumer's legal representative, or the clients' rights advocate has not objected in writing to the appointing authority within five business days of receipt of the notice, or the appointing authority, upon review of the objection has determined that the circumstances on which the adverse action is based are egregious or threaten the health, safety, or life of the consumer or other consumers and without the information the adverse action could not be taken.

(ii) The appointing authority, the person against whom the adverse action has been taken, and the person's representative, if any, have entered into a stipulation that does all of the following:

(I) Prohibits the parties from disclosing or using the information or records for any purpose other than the proceedings for which the information or records were requested or provided.

(II) Requires the employee and the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representative because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

1 (III) Requires the parties to submit the stipulation to the
2 administrative tribunal with jurisdiction over the adverse action
3 at the earliest possible opportunity.

4 (2) For the purposes of this subdivision, the State Personnel
5 Board may, prior to any appeal from adverse action being filed
6 with it, issue a protective order, upon application by the appointing
7 authority, for the limited purpose of prohibiting the parties from
8 disclosing or using information or records for any purpose other
9 than the proceeding for which the information or records were
10 requested or provided, and to require the employee or the
11 employee's legal representative to return to the appointing authority
12 all records provided to them under this subdivision, including, but
13 not limited to, all records and documents from any source
14 containing confidential information protected by this section, and
15 all copies of those records and documents, within 10 days of the
16 date that the adverse action becomes final, except for the actual
17 records and documents or copies thereof that are no longer in the
18 possession of the employee or the employee's legal representatives
19 because they were submitted to the administrative tribunal as a
20 component of an appeal from the adverse action.

21 (3) Individual identifiers, including, but not limited to, names,
22 social security numbers, and hospital numbers, that are not
23 necessary for the prosecution or defense of the adverse action,
24 shall not be disclosed.

25 (4) All records, documents, or other materials containing
26 confidential information protected by this section that have been
27 submitted or otherwise disclosed to the administrative agency or
28 other person as a component of an appeal from an adverse action
29 shall, upon proper motion by the appointing authority to the
30 administrative tribunal, be placed under administrative seal and
31 shall not, thereafter, be subject to disclosure to any person or entity
32 except upon the issuance of an order of a court of competent
33 jurisdiction.

34 (5) For purposes of this subdivision, an adverse action becomes
35 final when the employee fails to answer within the time specified
36 in Section 19575 of the Government Code, or, after filing an
37 answer, withdraws the appeal, or, upon exhaustion of the
38 administrative appeal or of the judicial review remedies as
39 otherwise provided by law.

1 (y) To the person appointed as the developmental services
2 decisionmaker for a minor, dependent, or ward pursuant to Section
3 319, 361, or 726.

4 (z) *To a business associate or for health care operations*
5 *purposes, in accordance with Part 160 (commencing with Section*
6 *160.101) and Part 164 (commencing with Section 164.102) of*
7 *Subchapter C of Subtitle A of Title 45 of the Code of Federal*
8 *Regulations.*

9 SEC. 3. No reimbursement is required by this act pursuant to
10 Section 6 of Article XIII B of the California Constitution because
11 the only costs that may be incurred by a local agency or school
12 district will be incurred because this act creates a new crime or
13 infraction, eliminates a crime or infraction, or changes the penalty
14 for a crime or infraction, within the meaning of Section 17556 of
15 the Government Code, or changes the definition of a crime within
16 the meaning of Section 6 of Article XIII B of the California
17 Constitution.

AMENDED IN SENATE APRIL 17, 2017
AMENDED IN SENATE MARCH 20, 2017

SENATE BILL

No. 419

Introduced by Senator Portantino

February 15, 2017

An act to add Section 2242.3 to the Business and Professions Code, relating to controlled substances. An act to amend Section 2241.6 of, and to add Section 4075.7 to, the Business and Professions Code, and to add Section 11167.7 to the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 419, as amended, Portantino. ~~Oxycodone: prescriptions. Medical practice: pain management.~~

Existing law, the Controlled Substances Act, prohibits a person other than a physician, dentist, podiatrist, veterinarian, or certain other health care practitioners, in specified circumstances, from writing or issuing a prescription. That act requires a prescription for specified controlled substances to be made on a specified controlled substance prescription form, to be signed and dated by the prescriber in ink, and to contain specified information. That act requires a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance to consult the Controlled Substance Utilization Review and Evaluation System database to review a patient's controlled substance history before prescribing specified controlled substances to the patient for the first time, and at least once every 4 months thereafter if the substance remain part of the treatment of the patient, except as specified. That act prohibits a person from prescribing, administering, or dispensing a controlled substance to an addict or any person

representing himself or herself as an addict, except as specified. That act defines “addict” for this purpose, and excludes from the definition a person whose drug-seeking behavior is primarily due to the inadequate control of pain. Existing law, the Pharmacy Law, imposes various requirements on the dispensing by prescription of dangerous drugs, including controlled substances. That law prohibits furnishing a prescription for a controlled substance transmitted by means of an oral or electronically transmitted order to any person unknown and unable to properly establish his or her identity. Existing law makes a violation of these provisions a crime.

This bill would require a specified health care practitioner, before prescribing, ordering, or furnishing specified narcotic pain medications, including controlled substances, to a minor, as defined, to educate the guardian of the minor on all other available medical treatments, specified nonopioid treatment alternatives to be tried before and alongside opioid therapy, the risks and benefits of narcotic medications and alternatives to narcotic medications, the safe storage of opioid medications, the proper disposal of unused medications, and the illegality of sharing or misusing prescribed medications. The bill would also require this discussion and counseling to be memorialized in a document printed on a secure prescription pad and signed by the minor, if he or she was counseled, the guardian, and the prescriber. The bill would require a pharmacist to review and verify the document before dispensing the medication. The bill would prohibit a subsequent prescription of those medications from being made until the minor is reevaluated by a pain management specialist or a pediatrician. By adding these new requirements to the Controlled Substances Act and the Pharmacy Law, the violation of which would be a crime, this bill would impose a state-mandated local program.

Existing law establishes the Medical Board of California within the Department of Consumer Affairs. Existing law, among other things, required the board to develop standards before June 1, 2002, to ensure the competent review in cases concerning the management, including, but not limited to, the undertreatment, undermedication, and overmedication of a patient’s pain.

This bill would require the board, on or before July 1, 2018, to update those standards. The bill would also require the board to update those standards on or before July 1 each 5th year thereafter. The bill would require the board to convene a task force to develop and recommend the updated standards to the board. The bill would require the task

force, in developing the updated standards, to consult with specified entities.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V. Existing law places oxycodone within Schedule II. Existing law requires a prescription for a controlled substance to only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice.~~

~~Existing law, the Medical Practice Act, provides for the licensing and regulation of physicians and surgeons by the Medical Board of California. Among other things, the act regulates the prescribing, dispensing, or furnishing of dangerous drugs, including oxycodone, by a licensee, and provides, under certain circumstances, for the imposition of an administrative fine pursuant to a citation by the board, or the imposition of a civil penalty for a violation of these provisions. A violation of designated provisions of the act is a crime.~~

~~This bill would prohibit a person from prescribing oxycodone, by whatever official, common, usual, chemical, or trade name designated, to a patient under 21 years of age, except as specified. The bill would make a violation of this prohibition subject to a civil penalty, as specified. The bill would also authorize a patient who was prescribed oxycodone in violation of the prohibition, and who sustained economic loss or personal injury as a result of that violation, to bring a civil action to recover compensatory damages, reasonable attorney's fees, and litigation costs.~~

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: ~~no~~yes.

The people of the State of California do enact as follows:

1 *SECTION 1. Section 2241.6 of the Business and Professions*
2 *Code is amended to read:*

3 ~~2241.6. The Division of Medical Quality shall develop~~
4 ~~standards before June 1, 2002, to assure the competent review in~~
5 ~~cases concerning the management, including, but not limited to,~~
6 ~~the undertreatment, undermedication, and overmedication of a~~
7 ~~patient's pain. The division~~

8 2241.6. (a) (1) *The board shall develop standards before June*
9 *1, 2002, to ensure the competent review in cases concerning the*
10 *management, including, but not limited to, the undertreatment,*
11 *undermedication, and overmedication of a patient's pain.*

12 (2) *The board may consult with entities such as the American*
13 *Pain Society, the American Academy of Pain Medicine, the*
14 *California Society of Anesthesiologists, the California Chapter of*
15 *the American College of Emergency Physicians, and any other*
16 *medical entity specializing in pain control therapies to develop the*
17 *standards utilizing, to the extent they are applicable, current*
18 *authoritative clinical practice guidelines.*

19 (b) *The board shall update the standards adopted pursuant to*
20 *subdivision (a) on or before July 1, 2018, and on or before July 1*
21 *each fifth year thereafter.*

22 (c) *The board shall convene a task force to develop and*
23 *recommend the updated standards to the board. The task force, in*
24 *developing the updated standards, shall consult with the entities*
25 *specified in paragraph (2) of subdivision (a), the American Cancer*
26 *Society, and specialists in pharmacology and addiction medicine.*

27 SEC. 2. *Section 4075.7 is added to the Business and Professions*
28 *Code, to read:*

29 4075.7. (a) *Before dispensing a prescription for a minor for*
30 *a pain medication listed in Section 11167.7 of the Health and*
31 *Safety Code, the pharmacist shall review and verify the disclosure*
32 *and counseling document described in subdivision (c) of Section*
33 *11167.7 of the Health and Safety Code.*

34 (b) *For purposes of this section, "minor" shall have the same*
35 *meaning as in Section 11167.7 of the Health and Safety Code.*

36 SEC. 3. *Section 11167.7 is added to the Health and Safety*
37 *Code, to read:*

1 11167.7. (a) For purposes of this section, the following
2 definitions shall apply:

3 (1) “Minor” means a person under 18 years of age who is not
4 any of the following:

5 (A) A cancer patient.

6 (B) A patient in hospice or palliative care.

7 (C) A patient who has been diagnosed with a terminal illness.

8 (2) “Guardian” means the legal guardian of the minor.

9 (b) A health care practitioner, except a veterinarian, authorized
10 to prescribe, order, administer, or furnish oxycodone, hydrocodone,
11 hydromorphone, morphine, codeine, oxymorphone, fentanyl,
12 methadone, tramadol, or tapentadol to a minor shall, before
13 prescribing, ordering, administering, or furnishing those
14 medications, educate the guardian on all of the following:

15 (1) All other available medical treatments, other than the
16 medication to be prescribed.

17 (2) Nonopioid treatment alternatives to be tried before and
18 alongside opioid therapy, unless there is a specific adverse reaction
19 or contraindication.

20 (3) The risks and benefits of narcotic medications and
21 alternatives.

22 (4) The safe storage of opioid medications.

23 (5) The proper disposal of unused medications.

24 (6) The illegality of sharing or misusing prescribed medications.

25 (c) The discussion and counseling provided in subdivision (b)
26 shall be memorialized in a document printed on a secure
27 prescription pad and signed by the minor, if he or she was
28 counseled, the guardian, and the prescriber.

29 (d) A subsequent prescription for the pain medications listed in
30 subdivision (b) shall not be made until the minor is reevaluated
31 by a pain management specialist or a pediatrician.

32 SEC. 4. No reimbursement is required by this act pursuant to
33 Section 6 of Article XIII B of the California Constitution because
34 the only costs that may be incurred by a local agency or school
35 district will be incurred because this act creates a new crime or
36 infraction, eliminates a crime or infraction, or changes the penalty
37 for a crime or infraction, within the meaning of Section 17556 of
38 the Government Code, or changes the definition of a crime within
39 the meaning of Section 6 of Article XIII B of the California
40 Constitution.

1 SECTION 1. ~~Section 2242.3 is added to the Business and~~
2 ~~Professions Code, to read:~~

3 ~~2242.3. (a) (1) Notwithstanding any other law, a person shall~~
4 ~~not prescribe oxycodone, by whatever official, common, usual,~~
5 ~~chemical, or trade name designated, to a patient under 21 years of~~
6 ~~age.~~

7 ~~(2) Paragraph (1) does not apply with respect to a patient of any~~
8 ~~age who is any of the following:~~

9 ~~(A) A cancer patient.~~

10 ~~(B) A patient in hospice or palliative care.~~

11 ~~(C) A patient who has been diagnosed with a terminal illness.~~

12 ~~(b) (1) Notwithstanding Section 2314 or any other law, a~~
13 ~~violation of this section may subject the person who has committed~~
14 ~~the violation to either a fine of up to five thousand dollars (\$5,000)~~
15 ~~per violation pursuant to a citation issued by the board or a civil~~
16 ~~penalty of up to five thousand dollars (\$5,000) per violation.~~

17 ~~(2) The Attorney General may bring an action to enforce this~~
18 ~~section and to collect the fines or civil penalties authorized by~~
19 ~~paragraph (1).~~

20 ~~(c) In addition to the penalties described in paragraph (1) of~~
21 ~~subdivision (b), a patient who was prescribed oxycodone in~~
22 ~~violation of subdivision (a), and who sustained economic loss or~~
23 ~~personal injury as a result of that violation, may bring an action~~
24 ~~to recover compensatory damages, as well as reasonable attorney's~~
25 ~~fees and costs.~~

AMENDED IN SENATE APRIL 17, 2017

SENATE BILL

No. 457

Introduced by Senator Bates

February 16, 2017

~~An act to amend Section 1248 of the Health and Safety Code, relating to health facilities. An act to amend Section 2507 of, to add Section 2746.54 to, to add Article 17 (commencing with Section 880) to Chapter 1 of Division 2 of, and to repeal Sections 2508, 2510, 2516 of, the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to out-of-hospital childbirths.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 457, as amended, Bates. ~~Health facilities: outpatient settings. Out-of-Hospital Childbirths: physicians and surgeons: licensed midwives: certified nurse-midwives.~~

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.

Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensure and regulation of midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes a licensed midwife to attend cases of normal pregnancy and childbirth, but requires a midwife to immediately refer or transfer a client to a physician and surgeon if there are complications. Under the act, if a client of a licensed midwife is transferred to a hospital, the licensed midwife is required to provide records and speak with the receiving physician and surgeon about labor up to the point of the transfer. The act requires a hospital to report each transfer of a planned out-of-hospital birth to the Medical Board of California and the

California Maternal Quality Care Collaborative using a standardized form developed by the board. Under existing law, a midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of certified nurse-midwives by the Board of Registered Nursing. A violation of the act is a crime. Existing law authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. Existing law authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistent with the certified nurse-midwife's educational preparation or clinical competence to specified persons, and only in accordance with standardized procedures and protocols developed and approved by, among others, the supervising physician and surgeon.

Existing law establishes the Office of Statewide Health Planning and Development in state government and it has jurisdiction over health planning and research development.

This bill would revise and recast these provisions by requiring that a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife only attend cases of pregnancy and out-of-hospital childbirth, as defined, when specified conditions are met. For purposes of determining whether a patient or client satisfies these conditions, the bill would require the licensed physician and surgeon, licensed certified nurse midwife, or licensed midwife to use a self-screening form to identify patient or client risk factors for out-of-hospital childbirth. The bill would specify those circumstances when a medical examination by a licensed physician and surgeon is required, when a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife is prohibited from attending cases of pregnancy and out-of-hospital childbirth, and when a licensed physician and surgeon, a licensed

midwife, and a certified nurse-midwife would be required to initiate appropriate interventions, including transfer to a hospital, when a patient or client's health status changes. The bill would make it unprofessional conduct for a licensed physician and surgeon, licensed midwife, or licensed certified nurse-midwife to attend to a case of out-of-hospital childbirth after a licensed physician and surgeon determines that the patient or client is at an increased risk due to her health status, as provided.

This bill would require licensed physician and surgeon, licensed midwife, or a licensed certified nurse-midwife attending to cases of out-of-hospital childbirths to make specified disclosures to a prospective patient or client and obtain consent, as provided. The bill would also require these licensees to provide the patient or client with the most recent versions of specified documents concerning out-of-hospital childbirths. The bill would also require the Medical Board of California and the Board of Registered Nursing to make those same documents publicly available on their Internet Web sites.

If a patient or client is transferred to a hospital, this bill would require the licensee to provide specified records and speak with the receiving physician and surgeon about the labor up to the point of the transfer. The bill would provide that the failure to comply with this requirement shall constitute unprofessional conduct. The bill would also require the hospital, within a specified period of time, to report to the Office of Statewide Health Planning and Development each transfer of a patient, as specified. The bill would require the Office of Statewide Health Planning and Development to develop a form, subject to specified criteria, including that patient identifying information is protected, for purposes of implementing the hospital reporting requirement.

This bill would require each licensee caring for a patient or client planning an out-of-hospital birth to submit, within a specified period of time, a form to the Office of Statewide Health Planning and Development indicating the initiation of care. The bill would also require each licensee who attends an out-of-hospital childbirth to annually submit a specified report to the Office of Statewide Health Planning and Development. The bill would require the Office of Statewide Health Planning and Development to, among other things, maintain the confidentiality of this information.

For consistency with the above provisions governing out-of-hospital childbirths, the bill would make conforming changes to the Licensed Midwifery Practice Act of 1993 and the Nursing Practice Act. The bill

would specify that a certified nurse-midwife is authorized to attend cases of out-of-hospital childbirth without physician and surgeon supervision when the provisions governing out-of-hospital childbirths are complied with. The bill would also authorize a licensed midwife and a certified nurse-midwife to administer, order, or use certain drugs and equipment. Because a violation of these requirements by a licensed midwife or certified nurse-midwife would be a crime under their respective acts, the bill would impose a state-mandated local program.

(2) Under existing law, an alternative birth center that is licensed as an alternative birth center specialty clinic is required to, as a condition of licensure, and a primary care clinic providing services as an alternative birth center is required to, meet specified certain requirements including requiring the presence of at least 2 attendants at all times during birth, one of whom is required to be a licensed physician and surgeon, licensed midwife, or a certified nurse-midwife.

This bill would require the client to be informed orally and in writing when no licensed physician and surgeon is present.

(3) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law prohibits the operation, management, conduct, or maintenance of an outpatient setting unless the outpatient setting is accredited by an accreditation agency that is approved by the Medical Board of California, licensed by the State Department of Public Health, as specified, or meets other criteria. Existing law defines an outpatient setting, in part, as a facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined, that uses anesthesia, as specified.~~

~~This bill would make technical, nonsubstantive changes to those provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes.
State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

1 SECTION 1. Article 17 (commencing with Section 880) is
2 added to Chapter 1 of Division 2 of the Business and Professions
3 Code, to read:

4
5 Article 17. Out-of-Hospital Childbirths
6

7 880. (a) Notwithstanding any other law and except as provided
8 in subdivisions (c) and (d), a licensed physician and surgeon, a
9 licensed midwife, and a certified nurse-midwife shall only attend
10 cases of pregnancy and out-of-hospital childbirth when all of the
11 following conditions are met:

12 (1) There is no increased risk to the patient or client because
13 of a disease or condition that could adversely affect the pregnancy
14 and childbirth.

15 (2) The patient or client has not had prior uterine or abdominal
16 surgery, including, but not limited to, myomectomy, hysterotomy,
17 or prior caesarian section.

18 (3) There is a singleton fetus.

19 (4) There is a cephalic presentation by 36⁰/₇ completed weeks
20 of pregnancy.

21 (5) The gestational age of the fetus is greater than 37⁰/₇ weeks
22 and less than 42⁰/₇ completed weeks of pregnancy.

23 (6) Labor is spontaneous or manually induced after 39 weeks
24 gestation.

25 (7) Transfer to a hospital setting can occur within 20 minutes
26 from the initiation of the transfer.

27 (b) The licensed physician and surgeon, licensed certified nurse
28 midwife, or licensed midwife, acting within their scope of practice,
29 shall use a self-screening form to identify patient or client risk
30 factors for out-of-hospital childbirth.

31 (c) If the patient or client meets the conditions specified in
32 paragraphs (3) to (7), inclusive, of subdivision (a), but fails to
33 meet the conditions specified in paragraph (1) or (2) of subdivision

1 (a) based on the risk factors identified by the self-screening form,
2 the patient or client shall obtain a medical examination by a
3 licensed physician and surgeon with privileges to practice
4 obstetrics or gynecology. Under these circumstances, the licensed
5 physician and surgeon, licensed midwife, or certified nurse midwife
6 may only attend cases of out-of-hospital childbirth if a licensed
7 physician and surgeon with privileges to practice obstetrics or
8 gynecology determines, at the time of the examination, that the
9 patient or client is not at an increased risk due to a disease or
10 condition, that could adversely affect the pregnancy and childbirth.

11 (d) The licensed physician and surgeon, licensed midwife, or
12 licensed certified nurse-midwife attending cases of pregnancy and
13 out-of-hospital childbirth under this article shall continuously
14 assess the patient or client for any evidence of a disease or
15 condition that could adversely affect the pregnancy and childbirth.
16 If any evidence of a disease or condition that could adversely affect
17 the pregnancy and childbirth arise, the patient or client shall obtain
18 a medical examination by a licensed physician and surgeon with
19 privileges to practice obstetrics or gynecology or the licensed
20 physician and surgeon, licensed midwife, or licensed certified
21 nurse-midwife, shall initiate appropriate interventions, including
22 transfer, first-responder emergency care or emergency transport.

23 (e) For the purposes of this article, “out-of-hospital childbirth”
24 means childbirth in the home setting, an alternative birth center
25 pursuant to paragraph (4) of subdivision (b) of Section
26 1204 of the Health and Safety Code, or any other setting other
27 than a facility as described in Chapter 2 (commencing with Section
28 1250) of Division 2 of the Health and Safety Code, or a facility as
29 described in Chapter 2.5 (commencing with Section 1440) of
30 Division 2 of the Health and Safety Code.

31 (f) It shall constitute unprofessional conduct for a licensed
32 physician and surgeon, licensed midwife, or licensed certified
33 nurse-midwife to attend to a case of out-of-hospital childbirth after
34 a licensed physician and surgeon with privileges in obstetrics or
35 gynecology, pursuant to a medical examination under subdivision
36 (c) or (d), determines that the patient or client is at an increased
37 risk due to a disease or condition, that could adversely affect the
38 pregnancy and childbirth. Notwithstanding any other law, a
39 violation of this section shall not be a crime.

1 880.2. (a) A licensed physician and surgeon, licensed midwife,
2 or a licensed certified nurse-midwife authorized to attend to cases
3 of out-of-hospital childbirths pursuant to this article shall disclose
4 in oral and written form to a prospective patient or client seeking
5 care for a planned out-of-hospital childbirth, and obtain consent
6 for, all of the following:

7 (1) All of the provisions of Section 880.

8 (2) The type of license held by the licensee and licensee number.

9 (3) A licensed midwife or certified nurse-midwife who attends
10 cases of out-of-hospital childbirth without physician and surgeon
11 supervision shall provide notice that the care being provided is
12 not being supervised by a physician and surgeon.

13 (4) The practice settings in which the licensee practices.

14 (5) If the licensee does not have professional liability coverage
15 for the care being provided in an out-of-hospital birth setting, he
16 or she shall disclose that fact.

17 (6) The acknowledgment that if the patient or client is required
18 to obtain an examination with a licensed physician and surgeon
19 pursuant to subdivision (c) or (d) of Section 880, failure to do so
20 may affect the patient or client's legal rights in any professional
21 negligence actions against a physician and surgeon, a healing arts
22 licensee, or hospital.

23 (7) There are conditions that will result in an examination from,
24 or transfer of care to, a licensed physician and surgeon and if
25 these conditions exist, the licensee will no longer be able to care
26 for the patient or client in an out-of-hospital setting, beyond
27 continuing care during the transition period to the physician and
28 surgeon.

29 (8) The specific arrangements for examination by a physician
30 and surgeon with privileges in obstetrics or gynecology for
31 examination. The licensee shall not be required to identify a
32 specific physician and surgeon.

33 (9) The specific arrangements for the transfer of care during
34 the prenatal period, hospital transfer during the intrapartum and
35 postpartum periods, and access to appropriate emergency medical
36 services for patient or client and newborn, if necessary, and
37 recommendations for preregistration at a hospital that has obstetric
38 emergency services and is most likely to receive the transfer.

1 (10) If, during the course of care, the patient or client has or
2 may have a condition indicating the need for a transfer to a
3 hospital, that the licensee shall initiate the transfer.

4 (11) The availability of the text of laws regulating out-of-hospital
5 childbirth and the procedure for reporting complaints to the
6 appropriate licensing entity.

7 (12) Consultation by a licensee with a consulting physician and
8 surgeon does not alone create a physician-patient relationship or
9 any other relationship with the consulting physician and surgeon.
10 The licensee shall inform the patient or client that he or she is an
11 independent healing arts licensee and is solely responsible for the
12 services he or she provides.

13 (b) The disclosure and consent form shall be signed by both the
14 licensee and patient or client and a copy of the signed disclosure
15 and consent form shall be placed in the patient or client's medical
16 record.

17 (c) (1) The licensee shall provide the patient or client with the
18 most recent versions of the following documents:

19 (A) The American College of Nurse-Midwives Clinical Bulletin
20 entitled "Midwifery Provision of Home Birth Services."

21 (B) The American College of Obstetricians and Gynecologists
22 on Obstetric Practice Committee Opinion #669: Planned Home
23 Birth.

24 (C) Society of Maternal Fetal Medicine and the American
25 College of Obstetricians and Gynecologists document entitled
26 "Obstetrics Care Consensus: Levels of Maternal Care."

27 (2) The Medical Board of California and the Board of Registered
28 Nursing shall make the most recent version of the documents
29 specified in paragraph (1) publicly available on their Internet Web
30 sites.

31 880.4. (a) If a patient or client is transferred to a hospital, the
32 licensee shall provide records, including prenatal records, and
33 speak with the receiving physician and surgeon about the labor
34 up to the point of the transfer. The failure to comply with this
35 section shall constitute unprofessional conduct. Notwithstanding
36 any other law, a violation of this section shall not be a crime.

37 (b) The hospital shall report, in writing on a form developed
38 by the Office of Statewide Health Planning and Development,
39 within 30 days, each transfer of a patient who attempted a planned

1 *out-of-hospital childbirth to the Office of Statewide Health*
2 *Planning and Development. The standardized form shall include:*

3 *(1) Name and license number of the licensed physician and*
4 *surgeon, certified nurse-midwife, or licensed midwife who attended*
5 *the patient's planned out-of-hospital childbirth or out-of-hospital*
6 *childbirth attempt.*

7 *(2) Name and license number of the accepting or admitting*
8 *physician and surgeon or certified nurse midwife who assumed*
9 *care of the patient.*

10 *(3) Name of the patient and patient identifying information.*

11 *(4) Name of the hospital or emergency center where the patient*
12 *was transferred.*

13 *(5) Date of report.*

14 *(6) Whether the person or persons admitted was pregnant, the*
15 *delivered mother, or newborn newborns.*

16 *(7) Whether there was a verbal handoff or if any prenatal*
17 *records were obtained from the out-of-hospital childbirth attendant.*

18 *(8) Gestational age of the fetus or newborn in weeks and method*
19 *of determination.*

20 *(9) Events triggering transfer including, but not limited to, pain*
21 *management, excessive bleeding, fetal intolerance of labor,*
22 *prolonged or nonprogressive labor with time in labor, maternal*
23 *request for transfer, or the clinical judgment of the out-of-birth*
24 *childbirth attendant.*

25 *(10) Presence of significant history and risk factors including,*
26 *but not limited to, preterm less than 37⁰/₇, postterm greater than*
27 *42⁰/₇, prior uterine or abdominal surgery including prior cesarean*
28 *section, Group B strep, multiple births, IUGR, IUFD,*
29 *chorioamnionitis, bleeding, noncephalic presentation, gestational*
30 *diabetes, morbid obesity (BMI >40), or preeclampsia.*

31 *(11) Method of delivery.*

32 *(12) Whether a caesarian section was performed.*

33 *(13) Place of delivery.*

34 *(14) FHR tracing on admission.*

35 *(15) Fetal presentation on admission.*

36 *(16) APGAR score of the newborn.*

37 *(17) Cord gases.*

38 *(18) Whether the newborn suffered any complications and was*
39 *placed in the NICU.*

1 (19) Whether the mother suffered any complications and was
2 placed in the ICU.

3 (20) Duration of hospital stay for the mother and the newborn
4 and newborns as of the date of the report and final disposition or
5 status, if not released from the hospital, of the mother and newborn
6 or newborns.

7 (c) The form described in subdivision (b) shall be constructed
8 in a format to enable the hospital to transmit the information in
9 paragraphs (4) to (20), inclusive, to the Office of Statewide Health
10 Planning and Development in a manner that the licensees and the
11 patient are anonymous and their identifying information is not
12 transmitted to the office. The entire form containing information
13 described in paragraphs (1) to (20), inclusive, of subdivision (b)
14 shall be placed in the patient's medical record.

15 (d) The Office of Statewide Health Planning and Development
16 may revise the reporting requirements for consistency with national
17 and standards, as applicable.

18 880.6. (a) Each licensee caring for a patient or client planning
19 an out-of-hospital birth shall submit, within 30 days of initial
20 acceptance of a patient or client, a form indicating the initiation
21 of care to the Office of Statewide Health Planning and
22 Development. The office shall develop a standardized form.

23 (b) Each licensee who attends an out-of-hospital childbirth,
24 including supervising a student midwife, shall annually report to
25 the Office of Statewide Health Planning and Development. The
26 report shall be submitted no later than March 30, for the prior
27 calendar year, in a form specified by the office and shall contain
28 all of the following:

29 (1) The licensee's name and license number.

30 (2) The calendar year being reported.

31 (3) The following information with regard to cases in California
32 in which the licensee, or the student midwife supervised by a
33 licensee, attended or assisted during the previous year when the
34 intended place of birth at the onset of care was an out-of-hospital
35 setting:

36 (A) The total number of patients or clients served as primary
37 caregiver at the onset of prenatal care.

38 (B) The number by county of live births attended as primary
39 caregiver.

1 (C) *The number, by county, of cases of fetal demise, infant*
2 *deaths, and maternal deaths attended as primary caregiver at the*
3 *discovery of the demise or death.*

4 (D) *The number of patients or clients whose primary care was*
5 *transferred to another health care practitioner during the*
6 *antepartum period, and the reason for each transfer.*

7 (E) *The number, reason, and outcome for each elective hospital*
8 *transfer during the intrapartum or postpartum period.*

9 (F) *The number, reason, and outcome for each urgent or*
10 *emergency transport of an expectant mother in the antepartum*
11 *period.*

12 (G) *The number, reason, and outcome for each urgent or*
13 *emergency transport of an infant or mother during the intrapartum*
14 *or immediate postpartum period.*

15 (H) *The number of planned out-of-hospital births at the onset*
16 *of labor and the number of births completed in an out-of-hospital*
17 *setting.*

18 (I) *The number of planned out-of-hospital births completed in*
19 *an out-of-hospital setting that were any of the following:*

20 (i) *Twin births.*

21 (ii) *Multiple births other than twin births.*

22 (iii) *Presentations other than cephalic.*

23 (iv) *Vaginal births after cesarean section (VBAC).*

24 (J) *A brief description of any complications resulting in the*
25 *morbidity or mortality of a mother or a neonate.*

26 (K) *Any other information prescribed by the Office of Statewide*
27 *Health Planning and Development in regulations.*

28 (c) *The Office of Statewide Health Planning and Development*
29 *shall maintain the confidentiality of the information submitted*
30 *pursuant to this section, and shall not permit any law enforcement*
31 *or regulatory agency to inspect or have copies made of the contents*
32 *of any reports submitted pursuant to subdivisions (a) and (b) for*
33 *any purpose, including, but not limited to, investigations for*
34 *licensing, certification, or any other regulatory purposes.*

35 (d) *The Office of Statewide Health Planning and Development*
36 *shall report to the appropriate board, by April 30, those licensees*
37 *who have met the requirements of this section for that year.*

38 (e) *The Office of Statewide Health Planning and Development*
39 *shall report the aggregate information collected pursuant to this*
40 *section to the appropriate board by July 30 of each year. The*

1 *Medical Board of California and the Board of Registered Nursing*
2 *shall include this information in its annual report to the*
3 *Legislature.*

4 *(f) The Office of Statewide Health Planning and Development,*
5 *with input from the appropriate licensing boards, may adjust the*
6 *data elements required to be reported to better coordinate with*
7 *other reporting systems, including the reporting system of the*
8 *Midwives Alliance of North America (MANA), while maintaining*
9 *the data elements unique to California. To better capture data*
10 *needed for the report required by this section, the concurrent use*
11 *of systems, including MANA's, by licensed midwives is encouraged.*

12 *(g) A failure to report under this section shall constitute*
13 *unprofessional conduct. Notwithstanding any other law, a violation*
14 *of this section shall not be a crime.*

15 *SEC. 2. Section 2507 of the Business and Professions Code is*
16 *amended to read:*

17 2507. (a) ~~The~~ *Notwithstanding any other law, the license to*
18 *practice midwifery authorizes the holder to attend cases of normal*
19 *pregnancy and childbirth, as defined in paragraph (1) of subdivision*
20 *(b), out-of-hospital childbirth pursuant to Article 17 (commencing*
21 *with Section 880), and to provide prenatal, intrapartum, and*
22 *postpartum care, including family planning care, for the mother,*
23 *care related to the out-of-hospital childbirth for the client and*
24 *immediate care for the newborn.*

25 (b) *As used in this article, the practice of midwifery constitutes*
26 *the furthering or undertaking by any licensed midwife to assist a*
27 *woman in childbirth as long as progress meets criteria accepted*
28 *as normal: client in an out-of-hospital childbirth pursuant to*
29 *pursuant to Article 17 (commencing with Section 880).*

30 ~~(1) Except as provided in paragraph (2), a licensed midwife~~
31 ~~shall only assist a woman in normal pregnancy and childbirth,~~
32 ~~which is defined as meeting all of the following conditions:~~

33 ~~(A) There is an absence of both of the following:~~

34 ~~(i) Any preexisting maternal disease or condition likely to affect~~
35 ~~the pregnancy.~~

36 ~~(ii) Significant disease arising from the pregnancy.~~

37 ~~(B) There is a singleton fetus.~~

38 ~~(C) There is a cephalic presentation.~~

39 ~~(D) The gestational age of the fetus is greater than 37 $\frac{0}{7}$ weeks~~
40 ~~and less than 42 $\frac{0}{7}$ completed weeks of pregnancy.~~

1 ~~(E) Labor is spontaneous or induced in an outpatient setting.~~

2 ~~(2) If a potential midwife client meets the conditions specified~~
3 ~~in subparagraphs (B) to (E), inclusive, of paragraph (1), but fails~~
4 ~~to meet the conditions specified in subparagraph (A) of paragraph~~
5 ~~(1), and the woman still desires to be a client of the licensed~~
6 ~~midwife, the licensed midwife shall provide the woman with a~~
7 ~~referral for an examination by a physician and surgeon trained in~~
8 ~~obstetrics and gynecology. A licensed midwife may assist the~~
9 ~~woman in pregnancy and childbirth only if an examination by a~~
10 ~~physician and surgeon trained in obstetrics and gynecology is~~
11 ~~obtained and the physician and surgeon who examined the woman~~
12 ~~determines that the risk factors presented by her disease or~~
13 ~~condition are not likely to significantly affect the course of~~
14 ~~pregnancy and childbirth.~~

15 ~~(3) The board shall adopt regulations pursuant to the~~
16 ~~Administrative Procedure Act (Chapter 3.5 (commencing with~~
17 ~~Section 11340) of Part of 1 of Division 3 of Title 2 of the~~
18 ~~Government Code) specifying the conditions described in~~
19 ~~subparagraph (A) of paragraph (1).~~

20 ~~(c) (1) If at any point during pregnancy, childbirth, or~~
21 ~~postpartum care a client's condition deviates from normal, the~~
22 ~~licensed midwife shall immediately refer or transfer the client to~~
23 ~~a physician and surgeon. *care, there is any evidence of a disease*~~
24 ~~*or condition that could adversely affect the pregnancy and*~~
25 ~~*childbirth arise, the client shall obtain a medical examination by*~~
26 ~~*a licensed physician and surgeon with privileges to practice*~~
27 ~~*obstetrics or gynecology pursuant to paragraph (b) of Section 880,*~~
28 ~~*or the licensed midwife shall initiate appropriate interventions,*~~
29 ~~*including immediate transfer, first-responder emergency care, or*~~
30 ~~*emergency transport.* The licensed midwife may consult and~~
31 ~~remain in consultation with the physician and surgeon after the~~
32 ~~referral or transfer.~~

33 ~~(2) If a physician and surgeon determines that the client's~~
34 ~~condition or concern has been resolved such that the risk factors~~
35 ~~presented by a woman's disease or condition are not likely to~~
36 ~~significantly affect the course of pregnancy or childbirth, *client is*~~
37 ~~*not at an increased risk due to a disease or condition, that could*~~
38 ~~*adversely affect the pregnancy and childbirth,* the licensed midwife~~
39 ~~may resume primary care of the client and resume assisting the~~
40 ~~client during *her the* pregnancy, childbirth, or postpartum care.~~

(3) If a physician and surgeon determines the client's condition or concern has not been resolved as specified in paragraph ~~(2)~~; (2) *and is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth*, the licensed midwife may provide concurrent care with a physician and surgeon and, if authorized by the client, be present during the labor and childbirth, and resume postpartum care, if appropriate. A licensed midwife shall ~~not resume primary care of the client. attend an out-of-hospital childbirth of the client.~~

(d) A licensed midwife shall not provide or continue to provide midwifery care to a ~~woman with a risk factor that will significantly affect the course of client~~ *if a licensed physician and surgeon with privileges to practice obstetrics or gynecology determines, at the time of the examination, that the client is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth as described in Article 17 (commencing with Section 880) pregnancy and childbirth, regardless of whether the woman client has consented to this care or refused care by a physician or surgeon, except as provided in paragraph (3) of subdivision (c).*

(e) The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version of these means.

~~(f) A midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.~~

(f) A licensed midwife may administer, order, or use any of the following:

- (1) Postpartum antihemorrhagic drugs.*
- (2) Prophylactic ophthalmic antibiotics.*
- (3) Vitamin K.*
- (4) RhoGAM.*
- (5) Local anesthetic medications.*
- (6) Intravenous fluids limited to lactated ringers, 5 percent dextrose with lactated ringers, and heparin and 0.9 percent sodium chloride for use in intravenous locks.*
- (7) Epinephrine for use in maternal anaphylaxis pending emergency transport.*
- (8) HBIG and GBV for neonates born to hepatitis B mothers, per current Centers for Disease Control guidelines.*

1 (9) Antibiotics for intrapartum prophylaxis of Group B
2 Betahemolytic Streptococcus (GBBS), per current Centers For
3 Disease Control guidelines.

4 (10) Equipment incidental to the practice of out-of-hospital
5 childbirth, specifically, dopplers, syringes, needles, phlebotomy
6 equipment, suture, urinary catheters, intravenous equipment,
7 amnihooks, airway suction devices, neonatal and adult
8 resuscitation equipment, glucometer, and centrifuge.

9 (11) Equipment incidental to maternal care, specifically,
10 compression stockings, maternity belts, breast pumps, diaphragms,
11 and cervical caps.

12 (g) This article does not authorize a midwife to practice medicine
13 or to perform surgery.

14 SEC. 3. Section 2508 of the Business and Professions Code is
15 repealed.

16 2508. (a) ~~A licensed midwife shall disclose in oral and written~~
17 ~~form to a prospective client as part of a client care plan, and obtain~~
18 ~~informed consent for, all of the following:~~

19 ~~(1) All of the provisions of Section 2507.~~

20 ~~(2) The client is retaining a licensed midwife, not a certified~~
21 ~~nurse-midwife, and the licensed midwife is not supervised by a~~
22 ~~physician and surgeon.~~

23 ~~(3) The licensed midwife's current licensure status and license~~
24 ~~number.~~

25 ~~(4) The practice settings in which the licensed midwife practices.~~

26 ~~(5) If the licensed midwife does not have liability coverage for~~
27 ~~the practice of midwifery, he or she shall disclose that fact. The~~
28 ~~licensed midwife shall disclose to the client that many physicians~~
29 ~~and surgeons do not have liability insurance coverage for services~~
30 ~~provided to someone having a planned out-of-hospital birth.~~

31 ~~(6) The acknowledgment that if the client is advised to consult~~
32 ~~with a physician and surgeon, failure to do so may affect the~~
33 ~~client's legal rights in any professional negligence actions against~~
34 ~~a physician and surgeon, licensed health care professional, or~~
35 ~~hospital.~~

36 ~~(7) There are conditions that are outside of the scope of practice~~
37 ~~of a licensed midwife that will result in a referral for a consultation~~
38 ~~from, or transfer of care to, a physician and surgeon.~~

1 ~~(8) The specific arrangements for the referral of complications~~
2 ~~to a physician and surgeon for consultation. The licensed midwife~~
3 ~~shall not be required to identify a specific physician and surgeon.~~

4 ~~(9) The specific arrangements for the transfer of care during the~~
5 ~~pregnancy period, hospital transfer during the intrapartum and~~
6 ~~postpartum periods, and access to appropriate emergency medical~~
7 ~~services for mother and baby if necessary, and recommendations~~
8 ~~for preregistration at a hospital that has obstetric emergency~~
9 ~~services and is most likely to receive the transfer.~~

10 ~~(10) If, during the course of care, the client is informed that she~~
11 ~~has or may have a condition indicating the need for a mandatory~~
12 ~~transfer, the licensed midwife shall initiate the transfer.~~

13 ~~(11) The availability of the text of laws regulating licensed~~
14 ~~midwifery practices and the procedure for reporting complaints to~~
15 ~~the Medical Board of California, which may be found on the~~
16 ~~Medical Board of California's Internet Web site.~~

17 ~~(12) Consultation with a physician and surgeon does not alone~~
18 ~~create a physician-patient relationship or any other relationship~~
19 ~~with the physician and surgeon. The informed consent shall~~
20 ~~specifically state that the licensed midwife and the consulting~~
21 ~~physician and surgeon are not employees, partners, associates,~~
22 ~~agents, or principals of one another. The licensed midwife shall~~
23 ~~inform the patient that he or she is independently licensed and~~
24 ~~practicing midwifery and in that regard is solely responsible for~~
25 ~~the services he or she provides.~~

26 ~~(b) The disclosure and consent shall be signed by both the~~
27 ~~licensed midwife and the client and a copy of the disclosure and~~
28 ~~consent shall be placed in the client's medical record.~~

29 ~~(c) The Medical Board of California may prescribe the form for~~
30 ~~the written disclosure and informed consent statement required to~~
31 ~~be used by a licensed midwife under this section.~~

32 ~~SEC. 4. Section 2510 of the Business and Professions Code is~~
33 ~~repealed.~~

34 ~~2510. If a client is transferred to a hospital, the licensed~~
35 ~~midwife shall provide records, including prenatal records, and~~
36 ~~speak with the receiving physician and surgeon about labor up to~~
37 ~~the point of the transfer. The hospital shall report each transfer of~~
38 ~~a planned out-of-hospital birth to the Medical Board of California~~
39 ~~and the California Maternal Quality Care Collaborative using a~~
40 ~~standardized form developed by the board.~~

1 *SEC. 5. Section 2516 of the Business and Professions Code is*
2 *repealed.*

3 ~~2516. (a) Each licensed midwife who assists, or supervises a~~
4 ~~student midwife in assisting, in childbirth that occurs in an~~
5 ~~out-of-hospital setting shall annually report to the Office of~~
6 ~~Statewide Health Planning and Development. The report shall be~~
7 ~~submitted no later than March 30, for the prior calendar year, in a~~
8 ~~form specified by the board and shall contain all of the following:~~

9 ~~(1) The midwife's name and license number.~~

10 ~~(2) The calendar year being reported.~~

11 ~~(3) The following information with regard to cases in California~~
12 ~~in which the midwife, or the student midwife supervised by the~~
13 ~~midwife, assisted during the previous year when the intended place~~
14 ~~of birth at the onset of care was an out-of-hospital setting:~~

15 ~~(A) The total number of clients served as primary caregiver at~~
16 ~~the onset of care.~~

17 ~~(B) The number by county of live births attended as primary~~
18 ~~caregiver.~~

19 ~~(C) The number, by county, of cases of fetal demise, infant~~
20 ~~deaths, and maternal deaths attended as primary caregiver at the~~
21 ~~discovery of the demise or death.~~

22 ~~(D) The number of women whose primary care was transferred~~
23 ~~to another health care practitioner during the antepartum period,~~
24 ~~and the reason for each transfer.~~

25 ~~(E) The number, reason, and outcome for each elective hospital~~
26 ~~transfer during the intrapartum or postpartum period.~~

27 ~~(F) The number, reason, and outcome for each urgent or~~
28 ~~emergency transport of an expectant mother in the antepartum~~
29 ~~period.~~

30 ~~(G) The number, reason, and outcome for each urgent or~~
31 ~~emergency transport of an infant or mother during the intrapartum~~
32 ~~or immediate postpartum period.~~

33 ~~(H) The number of planned out-of-hospital births at the onset~~
34 ~~of labor and the number of births completed in an out-of-hospital~~
35 ~~setting.~~

36 ~~(I) The number of planned out-of-hospital births completed in~~
37 ~~an out-of-hospital setting that were any of the following:~~

38 ~~(i) Twin births.~~

39 ~~(ii) Multiple births other than twin births.~~

40 ~~(iii) Breech births.~~

1 ~~(iv) Vaginal births after the performance of a cesarean section.~~
2 ~~(J) A brief description of any complications resulting in the~~
3 ~~morbidity or mortality of a mother or a neonate.~~

4 ~~(K) Any other information prescribed by the board in~~
5 ~~regulations.~~

6 ~~(b) The Office of Statewide Health Planning and Development~~
7 ~~shall maintain the confidentiality of the information submitted~~
8 ~~pursuant to this section, and shall not permit any law enforcement~~
9 ~~or regulatory agency to inspect or have copies made of the contents~~
10 ~~of any reports submitted pursuant to subdivision (a) for any~~
11 ~~purpose, including, but not limited to, investigations for licensing,~~
12 ~~certification, or regulatory purposes.~~

13 ~~(c) The office shall report to the board, by April 30, those~~
14 ~~licensees who have met the requirements of subdivision (a) for~~
15 ~~that year.~~

16 ~~(d) The board shall send a written notice of noncompliance to~~
17 ~~each licensee who fails to meet the reporting requirement of~~
18 ~~subdivision (a). Failure to comply with subdivision (a) will result~~
19 ~~in the midwife being unable to renew his or her license without~~
20 ~~first submitting the requisite data to the Office of Statewide Health~~
21 ~~Planning and Development for the year for which that data was~~
22 ~~missing or incomplete. The board shall not take any other action~~
23 ~~against the licensee for failure to comply with subdivision (a).~~

24 ~~(e) The board, in consultation with the office and the Midwifery~~
25 ~~Advisory Council, shall devise a coding system related to data~~
26 ~~elements that require coding in order to assist in both effective~~
27 ~~reporting and the aggregation of data pursuant to subdivision (f).~~
28 ~~The office shall utilize this coding system in its processing of~~
29 ~~information collected for purposes of subdivision (f).~~

30 ~~(f) The office shall report the aggregate information collected~~
31 ~~pursuant to this section to the board by July 30 of each year. The~~
32 ~~board shall include this information in its annual report to the~~
33 ~~Legislature.~~

34 ~~(g) The board, with input from the Midwifery Advisory Council,~~
35 ~~may adjust the data elements required to be reported to better~~
36 ~~coordinate with other reporting systems, including the reporting~~
37 ~~system of the Midwives Alliance of North America (MANA);~~
38 ~~while maintaining the data elements unique to California. To better~~
39 ~~capture data needed for the report required by this section, the~~

1 concurrent use of systems, including MANA's, by licensed
2 midwives is encouraged.

3 ~~(h) Notwithstanding any other law, a violation of this section~~
4 ~~shall not be a crime.~~

5 SEC. 6. Section 2746.54 is added to the Business and
6 Professions Code, to read:

7 2746.54. (a) Notwithstanding Section 2746.5 or any other law,
8 a certified nurse-midwife may attend cases of out-of-hospital
9 childbirth pursuant to Article 17 (commencing with Section 880),
10 and to provide prenatal, intrapartum, and postpartum care, related
11 to the out-of-hospital childbirth, for the client and immediate care
12 for the newborn without physician and surgeon supervision.

13 (b) (1) If at any point during pregnancy, childbirth, or
14 postpartum care there is any evidence of a disease or condition
15 that could adversely affect the pregnancy and childbirth arise, the
16 client shall obtain a medical examination by a licensed physician
17 and surgeon with privileges to practice obstetrics or gynecology
18 as described in Article 17 (commencing with Section 880), or the
19 certified nurse midwife shall initiate appropriate interventions,
20 including immediate transfer, first-responder emergency care, or
21 emergency transport. The certified nurse-midwife may consult and
22 remain in consultation with the physician and surgeon after the
23 referral or transfer.

24 (2) If a physician and surgeon determines that the client's
25 condition or concern has been resolved such that the risk factors
26 presented by a client's disease or condition does not adversely
27 affect the pregnancy or childbirth, the certified nurse midwife may
28 resume care of the client and resume assisting the client during
29 the pregnancy, out-of-hospital childbirth, or postpartum care.

30 (3) If a physician and surgeon determines the client's condition
31 or concern has not been resolved as specified in paragraph (2),
32 and is at an increased risk due to a disease or condition, that could
33 adversely affect the pregnancy and childbirth, the certified
34 nurse-midwife may provide concurrent care with a physician and
35 surgeon and, if authorized by the client, be present during the
36 labor and childbirth, and resume postpartum care, if appropriate.
37 Notwithstanding any other law, under the circumstances described
38 in this paragraph, a certified nurse-midwife shall not attend an
39 out-of-hospital birth of the client unless under the supervision of
40 a physician and surgeon pursuant to Section 2746.5.

1 (c) A certified nurse-midwife shall not provide or continue to
2 provide care to a client if a licensed physician and surgeon with
3 privileges to practice obstetrics or gynecology determines, at the
4 time of the examination, that there is an increased risk to the client
5 because of a disease or condition that could adversely affect the
6 pregnancy and childbirth, as described in Article 17 (commencing
7 with Section 880), regardless of whether the client has consented
8 to this care or refused care by a physician or surgeon, except as
9 provided in paragraph (3) of subdivision (b).

10 (d) This section does not include the assisting of childbirth by
11 any artificial, forcible, or mechanical means, nor the performance
12 of any version of these means.

13 (e) For purposes of attending an out-of-hospital childbirth
14 pursuant to this section, and notwithstanding Section 2746.51, a
15 certified nurse-midwife may administer, order, or use any of the
16 following:

17 (1) Postpartum antihemorrhagic drugs.

18 (2) Prophylactic ophthalmic antibiotics.

19 (3) Vitamin K.

20 (4) RhoGAM.

21 (5) Local anesthetic medications.

22 (6) Intravenous fluids limited to lactated ringers, 5 percent
23 dextrose with lactated ringers, and heparin and 0.9 percent sodium
24 chloride for use in intravenous locks.

25 (7) Epinephrine for use in maternal anaphylaxis pending
26 emergency transport.

27 (8) HBIG and GBV for neonates born to hepatitis B mothers,
28 per current Centers for Disease Control guidelines.

29 (9) Antibiotics for intrapartum prophylaxis of Group B
30 Betahemolytic Streptococcus (GBBS), per current Centers For
31 Disease Control guidelines.

32 (10) Equipment incidental to the practice of out-of-hospital
33 childbirth, specifically, dopplers, syringes, needles, phlebotomy
34 equipment, suture, urinary catheters, intravenous equipment,
35 amnihooks, airway suction devices, neonatal and adult
36 resuscitation equipment, glucometer, and centrifuge.

37 (11) Equipment incidental to maternal care, specifically,
38 compression stockings, maternity belts, breast pumps, diaphragms,
39 and cervical caps.

1 (f) *This section does not authorize a nurse midwife to practice*
2 *medicine or to perform surgery.*

3 SEC. 7. *Section 1204.3 of the Health and Safety Code is*
4 *amended to read:*

5 1204.3. (a) An alternative birth center that is licensed as an
6 alternative birth center specialty clinic pursuant to paragraph (4)
7 of subdivision (b) of Section 1204 shall, as a condition of licensure,
8 and a primary care clinic licensed pursuant to subdivision (a) of
9 Section 1204 that provides services as an alternative birth center
10 shall, meet all of the following requirements:

11 (1) Be a provider of comprehensive perinatal services as defined
12 in Section 14134.5 of the Welfare and Institutions Code.

13 (2) Maintain a quality assurance program.

14 (3) Meet the standards for certification established by the
15 American Association of Birth Centers, or at least equivalent
16 standards as determined by the state department.

17 (4) In addition to standards of the American Association of Birth
18 Centers regarding proximity to hospitals and presence of attendants
19 at births, meet both of the following conditions:

20 (A) Be located in proximity, in time and distance, to a facility
21 with the capacity for management of obstetrical and neonatal
22 emergencies, including the ability to provide cesarean section
23 delivery, within 30 minutes from time of diagnosis of the
24 emergency.

25 (B) Require the presence of at least two attendants at all times
26 during birth, one of whom shall be a physician and surgeon, a
27 licensed midwife, or a certified nurse-midwife. *If no licensed*
28 *physician and surgeon is present, the client shall be informed*
29 *orally and in writing that no licensed physician and surgeon is*
30 *present.*

31 (5) Have a written policy relating to the dissemination of the
32 following information to patients:

33 (A) A summary of current state laws requiring child passenger
34 restraint systems to be used when transporting children in motor
35 vehicles.

36 (B) A listing of child passenger restraint system programs
37 located within the county, as required by Section 27362 of the
38 Vehicle Code.

1 (C) Information describing the risks of death or serious injury
2 associated with the failure to utilize a child passenger restraint
3 system.

4 (b) The state department shall issue a permit to a primary care
5 clinic licensed pursuant to subdivision (a) of Section 1204
6 certifying that the primary care clinic has met the requirements of
7 this section and may provide services as an alternative birth center.
8 Nothing in this section shall be construed to require that a licensed
9 primary care clinic obtain an additional license in order to provide
10 services as an alternative birth center.

11 (c) (1) Notwithstanding subdivision (a) of Section 1206, no
12 place or establishment owned or leased and operated as a clinic or
13 office by one or more licensed health care practitioners and used
14 as an office for the practice of their profession, within the scope
15 of their license, shall be represented or otherwise held out to be
16 an alternative birth center licensed by the state unless it meets the
17 requirements of this section.

18 (2) Nothing in this subdivision shall be construed to prohibit
19 licensed health care practitioners from providing birth related
20 services, within the scope of their license, in a place or
21 establishment described in paragraph (1).

22 *SEC. 8. The Legislature finds and declares that Section 1 of*
23 *this act, which adds Section 880.6 to the Business and Professions*
24 *Code, imposes a limitation on the public's right of access to the*
25 *meetings of public bodies or the writings of public officials and*
26 *agencies within the meaning of Section 3 of Article I of the*
27 *California Constitution. Pursuant to that constitutional provision,*
28 *the Legislature makes the following findings to demonstrate the*
29 *interest protected by this limitation and the need for protecting*
30 *that interest:*

31 *In order to allow the Office of Statewide Health Planning and*
32 *Development to fully accomplish its goals, it is imperative to*
33 *protect the interests of those persons submitting information to*
34 *the office to ensure that any personal or sensitive information that*
35 *this act requires those persons to submit is protected as confidential*
36 *information.*

37 *SEC. 9. No reimbursement is required by this act pursuant to*
38 *Section 6 of Article XIII B of the California Constitution because*
39 *the only costs that may be incurred by a local agency or school*
40 *district will be incurred because this act creates a new crime or*

1 *infraction, eliminates a crime or infraction, or changes the penalty*
2 *for a crime or infraction, within the meaning of Section 17556 of*
3 *the Government Code, or changes the definition of a crime within*
4 *the meaning of Section 6 of Article XIII B of the California*
5 *Constitution.*

6 ~~SECTION 1. Section 1248 of the Health and Safety Code is~~
7 ~~amended to read:~~

8 ~~1248. For purposes of this chapter, the following definitions~~
9 ~~shall apply:~~

10 ~~(a) “Division” means the Medical Board of California. All~~
11 ~~references in this chapter to the division, the Division of Licensing~~
12 ~~of the Medical Board of California, or the Division of Medical~~
13 ~~Quality shall be deemed to refer to the Medical Board of California~~
14 ~~pursuant to Section 2002 of the Business and Professions Code.~~

15 ~~(b) (1) “Outpatient setting” means a facility, clinic, unlicensed~~
16 ~~clinic, center, office, or other setting that is not part of a general~~
17 ~~acute care facility, as defined in Section 1250, that uses anesthesia,~~
18 ~~except local anesthesia or peripheral nerve blocks, or both, in~~
19 ~~compliance with the community standard of practice, in doses that,~~
20 ~~when administered, have the probability of placing a patient at risk~~
21 ~~for loss of the patient’s life-preserving protective reflexes.~~

22 ~~(2) “Outpatient setting” also means a facility that offers in vitro~~
23 ~~fertilization, as defined in subdivision (b) of Section 1374.55.~~

24 ~~(3) “Outpatient setting” does not include, among other settings,~~
25 ~~a setting where anxiolytics and analgesics are administered, when~~
26 ~~done so in compliance with the community standard of practice,~~
27 ~~in doses that do not have the probability of placing the patient at~~
28 ~~risk for loss of the patient’s life-preserving protective reflexes.~~

29 ~~(c) “Accreditation agency” means a public or private~~
30 ~~organization that is approved to issue certificates of accreditation~~
31 ~~to outpatient settings by the board pursuant to Sections 1248.15~~
32 ~~and 1248.4.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 512
Author: Hernandez
Bill Date: July 17, 2017, Introduced
Subject: Health Care Practitioners: Stem Cell Therapy
Sponsor: Author

DESCRIPTION OF LEGISLATION:

This bill would require a health care practitioner that performs a stem cell therapy that is not approved by the United States Food and Drug Administration (FDA), to communicate this to his or her patients on a notice displayed in his or her office. This bill would also require the Medical Board of California (Board) to include data in its Annual Report on the number of complaints received and any disciplinary actions taken against its licensees who provide stem cell therapies.

ANALYSIS

This bill would require a health care practitioner to communicate the following information to a patient seeking stem cell therapy:

“THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW. This health care practitioner performs one or more stem cell therapies that have not yet been approved by the United States Food and Drug Administration. You are encouraged to consult your primary care physician prior to undergoing a stem cell therapy.”

This information would be required to be communicated to a patient in all of the following ways:

- In a prominent display in an area visible to patients in the health care practitioner’s office. These notices shall be at least eight and one-half inches by 11 inches and written in no less than 40-point type.
- Prior to providing the initial stem cell therapy, a health care practitioner shall provide the patient with the notice in writing. The notice shall be at least eight and one-half inches by 11 inches and written in no less than 40-point type.

This bill would specify that it does not apply to a health care practitioner who has obtained approval for an investigational new drug or device from the FDA for the use of HCT/Ps, which are defined as human cells, tissues, or cellular or tissue-based products as defined in section 1271.3 of Title 21 of the Code of Federal Regulations.

This bill would allow the licensing board having jurisdiction of the health care practitioner, including the Board to cite and fine the health care practitioner, not to exceed \$1,000 per violation. This bill would specify that no citation shall be issued and no fine shall be assessed

upon the first complaint against a health care practitioner for violation of this section. This bill would allow a citation and fine to be assessed upon a second or subsequent violation, not to exceed \$1,000.

This bill would also require the Board to include data in its Annual Report, beginning with the 2018-19 Annual Report, on the number of complaints received and any disciplinary actions taken against its licensees who provide stem cell therapies.

According to the author, “[p]eople suffering from chronic diseases or serious injuries, including back and joint pain, arthritis, macular degeneration, diabetes, Alzheimer’s, and Parkinson’s are often in search of new therapies that may alleviate symptoms when traditional medication has not helped. During their search, some patients may come across ‘stem cell clinics,’ which provide stem cell injection procedures, the most common of which involves extraction of fat tissue from the patient via liposuction, which is then broken down to isolate the stem cells and injected back into the patient where pain or other symptoms are present... These clinics often use preliminary, unrelated stem cell research results to justify providing stem cell procedures that have not been approved by the FDA to treat these diseases because there is limited evidence of the proven effectiveness in alleviating symptoms of serious disease... While patients may feel hopeless and desperate for a treatment for their disease or condition, uninformed patients sometimes agree to unacceptable health care and financial risks by obtaining non-FDA-approved stem cell procedures, and unfortunately, several reports of adverse effects due to non-FDA-approved injections of stem cells from these establishments have been reported, including tumor formation, increased pain, and even blindness in the case of three women in Florida. This bill will allow patients who are seeking medical treatment through stem cell products to make informed decisions about their health care.”

This bill would provide notification and information to patients seeking stem cell therapy that has not been approved by the FDA. This information would encourage patients to consult their primary care physician, which may help to protect consumers. The data reporting requirement is something that the Board could easily include in its Annual Report. Board staff suggests that the Board take a neutral position on this bill.

FISCAL: Minor and absorbable workload associated with issuing citation and fines to physicians and including data in the Board’s Annual Report; however, costs are likely negligible as the Board may also collect fines for second or subsequent offenses.

SUPPORT: International Society for Stem Cell Research

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY JULY 17, 2017

AMENDED IN ASSEMBLY JUNE 22, 2017

AMENDED IN ASSEMBLY JUNE 12, 2017

AMENDED IN SENATE APRIL 17, 2017

SENATE BILL

No. 512

Introduced by Senator Hernandez

February 16, 2017

An act to add Section 684 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 512, as amended, Hernandez. Health care practitioners: stem cell therapy.

Existing law provides for the licensure and regulation of various health care practitioners by boards and agencies within the Department of Consumer Affairs. Existing law requires a health care practitioner, as defined, to communicate to a patient his or her name, state-granted practitioner license type, and highest level of academic degree, in a specified manner.

This bill would require a *licensed* health care practitioner who performs a stem cell therapy that is not approved by the United States Food and Drug Administration (FDA) to communicate to his or her patient seeking stem cell therapy specified information regarding the provision of stem cell therapies on a specified notice in a prominent display in an area visible to patients in his or her office, posted conspicuously in the entrance of his or her office, and provided in writing to the patient prior to providing the initial stem cell therapy. The bill would not apply to a health care practitioner who has obtained

approval for an investigational new drug or device from the FDA for the use of human cells, tissues, or cellular or tissue-based products. The bill would authorize the licensing board having jurisdiction of the health care practitioner to cite and fine the health care practitioner, not to exceed \$1,000 per violation, as specified. *The bill would require the Medical Board of California to indicate in its annual report, commencing with the 2018–19 annual report, the number of complaints received and any disciplinary actions taken against its licensees who provide stem cell therapies.*

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 684 is added to the Business and
2 Professions Code, to read:
3 684. (a) For the purpose of this section:
4 (1) “FDA” means the United States Food and Drug
5 Administration.
6 (2) “HCT/Ps” means human cells, tissues, or cellular or
7 tissue-based products, as defined in Section 1271.3 of Title 21 of
8 the Code of Federal Regulations, as amended August 31, 2016, as
9 published in the Federal Register (81 Fed. Reg. 60223).
10 (3) “Stem cell therapy” means a therapy involving the use of
11 HCT/Ps.
12 (b) (1) A health care practitioner licensed under this division
13 who performs a stem cell therapy that is not FDA-approved shall
14 communicate to a patient seeking stem cell therapy the following
15 information in English:
16
17 “THIS NOTICE MUST BE PROVIDED TO YOU UNDER
18 CALIFORNIA LAW. This health care practitioner performs one
19 or more stem cell therapies that have not yet been approved by the
20 United States Food and Drug Administration. You are encouraged
21 to consult with your primary care physician prior to undergoing a
22 stem cell therapy.”
23
24 (2) The information in paragraph (1) shall be communicated to
25 the patient in all of the following ways:

1 (A) In a prominent display in an area visible to patients in the
2 health care practitioner's office and posted conspicuously in the
3 entrance of the health care practitioner's office. These notices shall
4 be at least eight and one-half inches by 11 inches and written in
5 no less than 40-point type.

6 (B) Prior to providing the initial stem cell therapy, a health care
7 practitioner shall provide the patient with the notice described in
8 paragraph (1) in writing. The notice shall be at least eight and
9 one-half inches by 11 inches and written in no less than 40-point
10 type.

11 (c) This section does not apply to a health care practitioner
12 licensed under this division who has obtained approval for an
13 investigational new drug or device from the FDA for the use of
14 HCT/Ps.

15 (d) (1) The licensing board having jurisdiction of the health
16 care practitioner may cite and fine the health care practitioner, not
17 to exceed one thousand dollars (\$1,000) per violation of this
18 section.

19 (2) No citation shall be issued and no fine shall be assessed
20 upon the first complaint against a health care practitioner who
21 violates this section.

22 (3) Upon a second or subsequent violation of this section, a
23 citation and administrative fine not to exceed one thousand dollars
24 (\$1,000) per violation may be assessed.

25 (e) *The Medical Board of California shall indicate in its annual*
26 *report, commencing with the 2018–19 annual report, the number*
27 *of complaints received and any disciplinary actions taken against*
28 *its licensees who provide stem cell therapies.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 554
Author: Stone
Bill Date: June 14, 2017, Amended
Subject: Nurse Practitioners: Physician Assistants: Buprenorphine
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow nurse practitioners (NPs) and physician assistants (PAs) to administer or provide buprenorphine to a patient when done in compliance with the provisions of the federal Comprehensive Addiction Recovery Act (CARA), as enacted on July 22, 2016.

BACKGROUND:

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

Buprenorphine was approved by the Food and Drug Administration in 2002 for the treatment (alone or in combination with naloxone) of opioid dependence. The efficacy of buprenorphine in the treatment of opioid dependence has consistently been demonstrated, and its use has been associated with new types of patients receiving addiction treatment. Similar to other opioids, buprenorphine produces euphoria and respiratory depression in a dose-dependent manner. However, unique to buprenorphine, these effects increase until, at moderate doses, the effects reach a plateau and no longer continue to increase, making respiratory depression less likely in a habituated opioid user.

ANALYSIS

This bill would specify that an NP is not prohibited from furnishing or ordering buprenorphine when done in compliance with the provisions of CARA, as enacted on July 22, 2016. This bill would also specify that a PA is not prohibited from administering or providing buprenorphine to a patient, or transmitting orally, or in

writing on a patient's record or in a drug order, an order to a person who may lawfully furnish buprenorphine, when done in compliance with the provisions of CARA. Both NPs and PAs must comply with the following CARA requirements:

- The requirement that the NP or PA complete not fewer than 24 hours of initial training provided by an organization listed in sub-subclause (aa) of subclause (II) of clause (iv) of subparagraph (G) of paragraph (2) of subdivision (g) of section 823 of Title 21 of the United States Code, or any other organization that the United States Secretary of Health and Human Services determines is appropriate for the purposes of that sub-subclause, that addresses the following:
 - Opioid maintenance and detoxification.
 - Appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder.
 - Initial and periodic patient assessments, including substance use monitoring.
 - Individualized treatment planning, overdose reversal, and relapse prevention.
 - Counseling and recovery support services.
 - Staffing roles and considerations.
 - Diversion control.
 - Other best practices, as identified by the United States Secretary of Health and Human Services.
- The alternative requirement that the NP or PA have other training or experience that the United States Secretary of Health and Human Services determines will demonstrate the ability of the NP or PA to treat and manage opiate-dependent patients.
- The requirement that the NP or PA be supervised by, or work in collaboration with, a licensed physician and surgeon.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill would conform California law to federal law enacted in 2016. This bill would allow NPs and PAs to administer or provide buprenorphine, as long as they meet the requirements specified in this bill and in federal law. This would help to ensure expanded access to buprenorphine, which is used to treat opioid addiction. This expansion seems reasonable and is in line with federal law. Board staff has confirmed with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) that the physician supervisor of the NP or PA must also have a waiver issued by SAMHSA to administer buprenorphine. As such, this bill will help further the Board's mission of consumer protection the Board is supportive of this bill.

FISCAL: None to the Board

SUPPORT: California Association for Nurse Practitioners
California Hospital Association
Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 14, 2017

AMENDED IN SENATE APRIL 17, 2017

AMENDED IN SENATE MARCH 27, 2017

SENATE BILL

No. 554

Introduced by Senator Stone

February 16, 2017

An act to add Sections 2836.4 and 3502.1.5 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 554, as amended, Stone. Nurse practitioners: physician assistants: buprenorphine.

Existing federal law requires practitioners, as defined, who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment to obtain annually a separate registration with the United States Attorney General for that purpose. Existing federal law authorizes waiver of the registration requirement for a qualifying practitioner who submits specified information to the United States Secretary of Health and Human Services. Existing federal law, the Comprehensive Addiction Recovery Act of 2016, defines a qualifying practitioner for these purposes to include, among other practitioners, a nurse practitioner or physician assistant who, among other requirements, has completed not fewer than 24 hours of *prescribed* initial training, *or has other training or experience* as specified, and is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by state law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

Existing state law, the Nursing Practice Act, establishes the Board of Registered Nursing in the Department of Consumer Affairs for the licensure and regulation of nurse practitioners. The act authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision.

This bill would prohibit construing the Nursing Practice Act or any provision of state law from prohibiting a nurse practitioner from furnishing or ordering buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act, as specified.

Existing state law, the Physician Assistant Practice Act, establishes the Physician Assistant Board within the jurisdiction of the Medical Board of California for the licensure and regulation of physician assistants. The act authorizes a physician assistant, while under the supervision of a licensed physician authorized to supervise a physician assistant, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication, as specified.

This bill would prohibit construing the Physician Assistant Practice Act or any provision of state law from prohibiting a physician assistant from administering or providing buprenorphine to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order for buprenorphine to a person who may lawfully furnish buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act, as specified.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 2836.4 is added to the Business and
- 2 Professions Code, to read:
- 3 2836.4. Neither this chapter nor any other provision of law
- 4 shall be construed to prohibit a nurse practitioner from furnishing
- 5 or ordering buprenorphine when done in compliance with the
- 6 provisions of the Comprehensive Addiction Recovery Act ~~(P.L.~~
- 7 *(Public Law* 114-198), as enacted on July 22, 2016, including the
- 8 following:
- 9 (a) The requirement that the nurse practitioner complete not
- 10 fewer than 24 hours of initial training provided by ~~the American~~

~~Society of Addiction Medicine, the American Academy of
Addiction Psychiatry, the American Medical Association, the
American Osteopathic Association, the American Nurses
Credentialing Center, the American Psychiatric Association, the
American Association of Nurse Practitioners, the American
Academy of Physician Assistants, an organization listed in
sub-subclause (aa) of subclause (II) of clause (iv) of subparagraph
(G) of paragraph (2) of subdivision (g) of Section 823 of Title 21
of the United States Code, or any other organization that the United
States Secretary of Health and Human Services determines is
appropriate for the purposes of that sub-subclause, that addresses
the following:~~

- ~~(1) Opioid maintenance and detoxification.~~
- ~~(2) Appropriate clinical use of all drugs approved by the Food
and Drug Administration for the treatment of opioid use disorder.~~
- ~~(3) Initial and periodic patient assessments, including substance
use monitoring.~~
- ~~(4) Individualized treatment planning, overdose reversal, and
relapse prevention.~~
- ~~(5) Counseling and recovery support services.~~
- ~~(6) Staffing roles and considerations.~~
- ~~(7) Diversion control.~~
- ~~(8) Other best practices, as identified by the United States
Secretary of Health and Human Services.~~

~~(b) The *alternative* requirement that the nurse practitioner have
other training or experience that the United States Secretary of
Health and Human Services determines will demonstrate the ability
of the nurse practitioner to treat and manage opiate-dependent
patients.~~

~~(c) The requirement that the nurse practitioner be supervised
by, or work in collaboration with, a licensed physician and surgeon.~~

~~SEC. 2. Section 3502.1.5 is added to the Business and
Professions Code, to read:~~

~~3502.1.5. Neither this chapter nor any other provision of law
shall be construed to prohibit a physician assistant from
administering or providing buprenorphine to a patient, or
transmitting orally, or in writing on a patient's record or in a drug
order, an order to a person who may lawfully furnish buprenorphine
when done in compliance with the provisions of the Comprehensive~~

1 Addiction Recovery Act ~~(P.L. (Public Law 114-198)~~, as enacted
2 on July 22, 2016, including the following:

3 (a) The requirement that the physician assistant complete not
4 fewer than 24 hours of initial training provided by ~~the American~~
5 ~~Society of Addiction Medicine, the American Academy of~~
6 ~~Addiction Psychiatry, the American Medical Association, the~~
7 ~~American Osteopathic Association, the American Nurses~~
8 ~~Credentialing Center, the American Psychiatric Association, the~~
9 ~~American Association of Nurse Practitioners, the American~~
10 ~~Academy of Physician Assistants, an organization listed in~~
11 ~~sub-subclause (aa) of subclause (II) of clause (iv) of subparagraph~~
12 ~~(G) of paragraph (2) of subdivision (g) of Section 823 of Title 21~~
13 ~~of the United States Code, or any other organization that the United~~
14 ~~States Secretary of Health and Human Services determines is~~
15 ~~appropriate for the purposes of that sub-subclause, that addresses~~
16 the following:

- 17 (1) Opioid maintenance and detoxification.
- 18 (2) Appropriate clinical use of all drugs approved by the Food
19 and Drug Administration for the treatment of opioid use disorder.
- 20 (3) Initial and periodic patient assessments, including substance
21 use monitoring.
- 22 (4) Individualized treatment planning, overdose reversal, and
23 relapse prevention.
- 24 (5) Counseling and recovery support services.
- 25 (6) Staffing roles and considerations.
- 26 (7) Diversion control.
- 27 (8) Other best practices, as identified by the United States
28 Secretary of Health and Human Services.
- 29 (b) The *alternative* requirement that the physician assistant have
30 other training or experience that the United States Secretary of
31 Health and Human Services determines will demonstrate the ability
32 of the nurse practitioner to treat and manage opiate-dependent
33 patients.
- 34 (c) The requirement that the physician assistant be supervised
35 by, or work in collaboration with, a licensed physician and surgeon.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 641
Author: Lara
Bill Date: April 20, 2017, Amended
Subject: CURES: Privacy
Sponsor: California Medical Association
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the Department of Justice (DOJ) shall only provide data obtained from the Controlled Substance Utilization Review and Evaluation System (CURES) to a federal, state, or local law enforcement agency pursuant to a warrant based on probable cause and issued at the request of the law enforcement agency engaged in an open and active criminal investigation regarding prescription drug abuse or diversion of controlled substances involving the individual to whom the requested information pertains.

BACKGROUND:

The CURES Program is currently housed in DOJ and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website.

SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

SB 482 (Lara, Chapter 708) was signed into law in 2016 and requires a health care practitioner that is authorized to prescribe, order, administer or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment, with specified exceptions. This bill requires a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed,

ordered, administered, furnished or dispensed. If a health care practitioner is exempted from checking CURES before prescribing a controlled substance for the first time pursuant to this bill, they are required to consult CURES before subsequently prescribing a controlled substance to the patient at least every four months thereafter if the substance remains part of the treatment of the patient. This bill specifies that it is not operative until six months after DOJ certifies that the CURES database is ready for statewide use and that DOJ has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in the Budget Act of 2016. This bill requires DOJ to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification. DOJ has not yet certified that the CURES database is ready for statewide use and the DOJ has adequate staff.

ANALYSIS

This bill would not change the Medical Board of California's (Board) access to CURES, although the original version of this bill would have. Now this bill only affects law enforcement agencies. Although the Department of Consumer Affairs, Health Quality Investigation Unit (HQIU) investigators that perform the Board's investigations are peace officers, they are performing the investigations on behalf of a regulatory board, so this bill would not apply to the Board's administrative investigations. However, there are a small portion of criminal investigations performed by HQIU investigators on behalf of the Board. This bill would impact those investigations, but there are only approximately 20 criminal investigations per year conducted on behalf of the Board.

Board staff did request a technical amendment to make it clear this bill only applies to criminal investigations. This technical amendment was made, as such, the Board is now neutral on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: California Medical Association (Sponsor)
American Academy of Pediatrics, California
American College of Physicians – California Services Chapter
California Dental Association
County Behavioral Health Directors Association

OPPOSITION: California Narcotics Officers Association
California Teamsters Public Affairs Council
Center for Public Interest Law, University of San Diego
Consumer Attorneys of California
Consumer Federation of California
Consumer Watchdog
Shatterproof
Troy and Alana Pack Foundation

AMENDED IN SENATE APRIL 20, 2017
AMENDED IN SENATE MARCH 28, 2017

SENATE BILL

No. 641

Introduced by Senator Lara

February 17, 2017

An act to amend Section 11165 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 641, as amended, Lara. Controlled Substance Utilization Review and Evaluation System: privacy.

Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires the operation of CURES to comply with all applicable federal and state privacy and security laws and regulations. Under existing law, data obtained from CURES may only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the department, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Existing law allows data obtained from CURES to be provided to public or private entities for statistical or research purposes, as approved by the department.

This bill would prohibit the release of data obtained from CURES to a law enforcement agency except pursuant to a ~~valid court order~~, *warrant based on probable cause*, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 11165 of the Health and Safety Code is
2 amended to read:

3 11165. (a) To assist health care practitioners in their efforts
4 to ensure appropriate prescribing, ordering, administering,
5 furnishing, and dispensing of controlled substances, law
6 enforcement and regulatory agencies in their efforts to control the
7 diversion and resultant abuse of Schedule II, Schedule III, and
8 Schedule IV controlled substances, and for statistical analysis,
9 education, and research, the Department of Justice shall, contingent
10 upon the availability of adequate funds in the CURES Fund,
11 maintain the Controlled Substance Utilization Review and
12 Evaluation System (CURES) for the electronic monitoring of, and
13 Internet access to information regarding, the prescribing and
14 dispensing of Schedule II, Schedule III, and Schedule IV controlled
15 substances by all practitioners authorized to prescribe, order,
16 administer, furnish, or dispense these controlled substances.

17 (b) The Department of Justice may seek and use grant funds to
18 pay the costs incurred by the operation and maintenance of
19 CURES. The department shall annually report to the Legislature
20 and make available to the public the amount and source of funds
21 it receives for support of CURES.

22 (c) (1) The operation of CURES shall comply with all
23 applicable federal and state privacy and security laws and
24 regulations.

25 (2) (A) CURES shall operate under existing provisions of law
26 to safeguard the privacy and confidentiality of patients. Data
27 obtained from CURES shall only be provided to appropriate state,
28 local, and federal public agencies for disciplinary, civil, or criminal
29 purposes and to other agencies or entities, as determined by the
30 Department of Justice, for the purpose of educating practitioners
31 and others in lieu of disciplinary, civil, or criminal actions. Data
32 may be provided to public or private entities, as approved by the
33 Department of Justice, for educational, peer review, statistical, or
34 research purposes, provided that patient information, including
35 any information that may identify the patient, is not compromised.

1 Further, data disclosed to any individual or agency as described
2 in this subdivision shall not be disclosed, sold, or transferred to
3 any third party, unless authorized by, or pursuant to, state and
4 federal privacy and security laws and regulations.

5 (B) The Department of Justice shall only provide data obtained
6 from CURES to a federal, state, or local law enforcement agency
7 pursuant to a ~~valid court order or~~ warrant based on probable cause
8 and issued at the request of a federal, state, or local law
9 enforcement agency engaged in an open and active *criminal*
10 investigation regarding prescription drug abuse or diversion of
11 prescription of controlled substances involving the individual to
12 whom the requested information pertains.

13 (C) The Department of Justice shall establish policies,
14 procedures, and regulations regarding the use, access, evaluation,
15 management, implementation, operation, storage, disclosure, and
16 security of the information within CURES, consistent with Section
17 11165.1.

18 (D) Notwithstanding subparagraph (A), a regulatory board
19 whose licensees do not prescribe, order, administer, furnish, or
20 dispense controlled substances shall not be provided data obtained
21 from CURES.

22 (3) In accordance with federal and state privacy laws and
23 regulations, a health care practitioner may provide a patient with
24 a copy of the patient's CURES patient activity report as long as
25 no additional CURES data is provided and keep a copy of the
26 report in the patient's medical record in compliance with
27 subdivision (d) of Section 11165.1.

28 (d) For each prescription for a Schedule II, Schedule III, or
29 Schedule IV controlled substance, as defined in the controlled
30 substances schedules in federal law and regulations, specifically
31 Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21
32 of the Code of Federal Regulations, the dispensing pharmacy,
33 clinic, or other dispenser shall report the following information to
34 the Department of Justice as soon as reasonably possible, but not
35 more than seven days after the date a controlled substance is
36 dispensed, in a format specified by the Department of Justice:

37 (1) Full name, address, and, if available, telephone number of
38 the ultimate user or research subject, or contact information as
39 determined by the Secretary of the United States Department of

1 Health and Human Services, and the gender, and date of birth of
2 the ultimate user.

3 (2) The prescriber's category of licensure, license number,
4 national provider identifier (NPI) number, if applicable, the federal
5 controlled substance registration number, and the state medical
6 license number of any prescriber using the federal controlled
7 substance registration number of a government-exempt facility.

8 (3) Pharmacy prescription number, license number, NPI number,
9 and federal controlled substance registration number.

10 (4) National Drug Code (NDC) number of the controlled
11 substance dispensed.

12 (5) Quantity of the controlled substance dispensed.

13 (6) International Statistical Classification of Diseases, 10th
14 revision (ICD-10) Code, if available.

15 (7) Number of refills ordered.

16 (8) Whether the drug was dispensed as a refill of a prescription
17 or as a first-time request.

18 (9) Date of origin of the prescription.

19 (10) Date of dispensing of the prescription.

20 (e) The Department of Justice may invite stakeholders to assist,
21 advise, and make recommendations on the establishment of rules
22 and regulations necessary to ensure the proper administration and
23 enforcement of the CURES database. All prescriber and dispenser
24 invitees shall be licensed by one of the boards or committees
25 identified in subdivision (d) of Section 208 of the Business and
26 Professions Code, in active practice in California, and a regular
27 user of CURES.

28 (f) The Department of Justice shall, prior to upgrading CURES,
29 consult with prescribers licensed by one of the boards or
30 committees identified in subdivision (d) of Section 208 of the
31 Business and Professions Code, one or more of the boards or
32 committees identified in subdivision (d) of Section 208 of the
33 Business and Professions Code, and any other stakeholder
34 identified by the department, for the purpose of identifying
35 desirable capabilities and upgrades to the CURES Prescription
36 Drug Monitoring Program (PDMP).

- 1 (g) The Department of Justice may establish a process to educate
- 2 authorized subscribers of the CURES PDMP on how to access and
- 3 use the CURES PDMP.

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AMENDED IN SENATE APRIL 25, 2017

SENATE BILL

No. 715

Introduced by Senator Newman

February 17, 2017

~~An act to amend Section 5503 of the Public Resources Code, relating to park districts. An act to amend Section 106 of the Business and Professions Code, relating to consumer affairs.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 715, as amended, Newman. ~~Park and open-space districts. Department of Consumer Affairs: regulatory boards: removal of board members.~~

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes the Governor to remove from office any member of any board within the department appointed by him or her, on specific grounds, including continued neglect of duties required by law.

This bill would specifically include the failure to attend meetings of the board as one example of continued neglect of duties required by law that the Governor can use as a reason to remove a member from a board.

~~Existing law provides a procedure for the formation of a regional park district, regional park and open-space district, or a regional open-space district.~~

~~This bill would make nonsubstantive changes to one of those provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 106 of the Business and Professions Code
2 is amended to read:

3 106. The Governor has power to remove from office at any
4 time, any member of any board appointed by him *or her* for
5 continued neglect of duties required by law, *which may include*
6 *the failure to attend board meetings*, or for incompetence, or
7 unprofessional or dishonorable conduct. Nothing in this section
8 shall be construed as a limitation or restriction on the power of the
9 Governor, conferred on him *or her* by any other ~~provision of law~~,
10 to remove any member of any board.

11 ~~SECTION 1. Section 5503 of the Public Resources Code is~~
12 ~~amended to read:~~

13 ~~5503. Whenever it is desired to form a district under this article,~~
14 ~~a petition requesting the creation and maintenance of a district,~~
15 ~~and describing the exterior boundaries of the proposed district~~
16 ~~shall be signed by at least 5,000 electors residing within the~~
17 ~~territory proposed to be included in the district. The petition shall~~
18 ~~be presented to the board of supervisors of the county containing~~
19 ~~the largest area within the proposed district.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 746
Author: Portantino
Bill Date: February 17, 2017, Introduced
Subject: Pupil Health: Physical Examinations
Sponsor: California Chiropractic Association
Position: Oppose Unless Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow doctors of chiropractic, naturopathic doctors, and nurse practitioners (NPs) to perform physical examinations for students in interscholastic athletic programs.

BACKGROUND:

The California Interscholastic Federation (CIF) oversees the protocols related to physical examinations for school interscholastic athletic programs. Existing law only allows these exams to be performed by a physician or a physician assistant in Section 49458 of the Education Code. In the past, schools have allowed chiropractors to execute sports physical forms. However, the Schools Insurance Authority published an Informational Review of the “Use of Chiropractors in School Sports Programs” and raised concerns about the use of chiropractors for these physical exams, as the examinations may exceed the chiropractic scope. The review also brings up a concern that for sports injuries an injury could have possibly been avoided through an examination by a physician, so the school may have liability if it has accepted a sports physical form from a chiropractor. Because of this review, the CIF bylaws define a health care provider as a physician or osteopathic physician, so schools in California currently do not allow chiropractors to perform sports physicals.

As noted by the California Attorney General, a chiropractor must not engage in any care or treatment that is not based on “...a system of treatment by manipulation of the joints of the human body, by manipulation of anatomical displacements, articulation of the spinal column, including its vertebrae and cord, and he may use all necessary, mechanical, hygienic and sanitary measures incident to the care of the body in connection with said system of treatment, but not for the purpose of treatment, and not including measures as would constitute the practice of medicine, surgery, osteopathy, dentistry, or optometry, and without the use of any drug or medicine included in materia medica.” 59 Op.Atty.Gen 420, 8-26-76, citing *Crees* at p. 214.

AB 1992 (Jones, 2016) included the exact same language as this bill. The Board took an oppose unless amended position on that bill, with the amendment being to only add NPs to the list of providers who can perform the physical examinations for student athletes.

ANALYSIS:

Chiropractors are authorized to perform certain types of limited examinations and evaluations, but there is currently no specific authorization for a chiropractor to perform sports physicals for student athletes. Existing law only allows physician assistants and physician and surgeons to perform physical examinations for interscholastic athletic programs. These sports physicals require a review of cardiac, neurologic and internal organ functioning, which is outside of the chiropractic and naturopathic scope of practice.

According to the author, “Under current law, doctors of chiropractic have been legally performing pre-participation sports physicals in California for over 30 years. An outdated section of the Education Code does not list all health care providers qualified to perform these physicals. Some school districts are only accepting these physicals when performed by a health care provider listed in the Education Code, for fear of a perceived increase in potential liability.”

Allowing a chiropractor or naturopathic doctor to perform and sign off on these physical examinations, which include an evaluation and possible diagnosis, could negatively impact the students receiving these examinations, as chiropractors do not receive the same level of medical education and training as physicians. The Board’s primary mission is consumer protection and the Board should oppose this change. However, allowing an NP, who is under the supervision of a physician, to perform these examinations seems reasonable, especially since physician assistants are already allowed to perform these examinations in existing law. The Board is opposed to this bill unless it is amended to only add NPs to the list of providers who can perform physical examinations for student athletes.

FISCAL: None

SUPPORT: California Chiropractic Association (Sponsor)
California Naturopathic Doctors Association
Southern California University of Health Sciences

OPPOSITION: California Academy of Family Physicians
California Academy of Pediatrics
American College of Emergency Physicians, California Chapter
California Medical Association
Medical Board of California (Unless Amended)

Introduced by Senator Portantino

February 17, 2017

An act to amend Section 49458 of the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

SB 746, as introduced, Portantino. Pupil health: physical examinations.

Existing law authorizes a physician and surgeon or physician assistant to perform a physical examination that is required for a pupil to participate in an interscholastic athletic program of a school.

This bill would additionally authorize a doctor of chiropractic, naturopathic doctor, or nurse practitioner practicing in compliance with the respective laws governing their profession to perform that physical examination.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 49458 of the Education Code is amended
- 2 to read:
- 3 49458. When a school district or a county superintendent of
- 4 schools requires a physical examination as a condition of
- 5 participation in an interscholastic athletic program, the physical
- 6 examination may be performed by a physician and ~~surgeon or~~
- 7 ~~surgeon~~, physician assistant practicing in compliance with Chapter
- 8 7.7 (commencing with Section 3500) of Division 2 of the Business
- 9 and Professions ~~Code~~. *Code, doctor of chiropractic practicing in*

1 *compliance with Chapter 2 (commencing with Section 1000) of*
2 *Division 2 of the Business and Professions Code, naturopathic*
3 *doctor practicing in compliance with Chapter 8.2 (commencing*
4 *with Section 3610) of Division 2 of the Business and Professions*
5 *Code, or nurse practitioner practicing in compliance with Article*
6 *8 (commencing with Section 2834) of Chapter 6 of Division 2 of*
7 *the Business and Professions Code.*

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 790
Author: McGuire
Bill Date: July 6, 2017 Amended
Subject: Health Care Providers: Gifts and Benefits
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would, on and after January 1, 2019, prohibit a manufacturer of a prescribed product from offering or giving a gift to a health care provider. This bill would prohibit a manufacturer of a prescribed product or an entity on behalf of a manufacturer of a prescribed product from providing a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research.

BACKGROUND:

The Physician Payments Sunshine Act is a 2010 federal healthcare law to increase transparency of financial relationships between health care providers and pharmaceutical manufacturers. The Sunshine Act requires manufacturers of drugs, medical devices, and biological and medical supplies, covered by the three federal health care programs Medicare, Medicaid, and State Children's Health Insurance Program, to collect and track all financial relationships with physicians and teaching hospitals and to report this data to the federal Centers for Medicare and Medicaid Services. The goal of the law is to increase the transparency of financial relationships between health care providers and pharmaceutical manufacturers and to uncover potential conflicts of interest.

Data from 2014 shows that California physicians received the highest number of payments from pharmaceutical companies than any state (\$1.44B) compared to the second and third ranking states, New York (\$517M) and Texas (\$435M), with Alaska at the bottom, receiving the lowest amount (\$1.8M). 2014 data also revealed almost 280,000 doctors received a total of more than 60,000 payments associated with four target drugs.

Nationally, about three quarters of doctors across five common medical specialties received at least one payment from a company in 2014. In Nevada, that number was over 90 percent. In Vermont, the state with the strictest gift regulations, the number fell below 24 percent.

The Office of the Inspector General of the U.S. Department of Health and Human Services cautioned drug companies about making excessive payments to physicians for consulting and offering inappropriate gifts.

California's largest hospitals such as Kaiser, the University of California Medical Centers, and Stanford have implemented policies restricting pharma gifts to doctors.

Eight other states and the District of Columbia have also adopted gift bans and restrictions.

ANALYSIS

This bill would define an allowable expenditure as any of the following:

- A payment by a manufacturer of a prescribed product to the sponsor of a significant educational, medical, scientific, or policy making conference or seminar, provided that the payment is not made directly to a health care professional or pharmacist. The funding must be used solely for bona fide educational purposes (can be used for meals and other food for conference participants), and all program content is objective, free from industry control, and does not promote specific products.
- Honoraria and payment of the expenses of a health care professional who serves on the faculty at a bona fide educational, medical, scientific, or policy making conference or seminar, if the honoraria or payment is governed by an explicit contract with specific deliverables that are restricted to medical issues and the content of the presentation is determined or at a minimum is reviewed and approved by the health care professional.
- For a bona fide clinical trial or a research project that constitutes a systematic investigation, is designed to develop or contribute to general knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals working in the particular field of inquiry. It can include compensation for services provided by investigators, health care professionals, or health care providers in connection with the bona fide clinical trial or research project; expenses paid on behalf of investigators, health care professionals, or health care providers in connection with the bona fide clinical trial or research project; and materials and supplies used in connection with the bona fide clinical trial or research project.
- Payment or reimbursement for reasonable expenses, including travel and lodging-related expenses, necessary for technical training of individual health care professionals on the administration of a prescribed product, if the commitment to provide those expenses and the amounts or categories of reasonable expenses to be paid are described in a written agreement between the health care provider and the manufacturer.
- Public health initiatives to develop replicable and sustainable model programs that embody best practices in disease screening and linages to care.
- Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally recognized discovery for which the provider holds an ownership right. This also includes royalties, licensing fees, and financial transactions related to joint ventures and partnerships with health care providers.
- A payment to a health care provider for participation in bona fide marketing research conducted by a third party, only if the payments are made by that third party and the sponsoring manufacturer is not informed of the identity of the participating health care provider.
- Other reasonable fees, payments, subsidies, or other economic benefits provided by a manufacturer of a prescribed product at fair market value.

- The payment of reasonable expenses of an individual related to the interview of the individual by a manufacturer in connection with a bona fide employment opportunity or for health care services on behalf of an employee of the manufacturer.
- Provision of meals for a health care provider that do not exceed \$250 per person, per year in value in addition to payments otherwise permitted under this subdivision.

This bill would define a gift as a payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided at no cost or less than full market value to a health care provider. A “gift” does not include any allowable expenditure defined in this bill, any payment, food, entertainment, travel, subscription, advance, service, or anything else of value for which the health care provider reimburses the cost at fair market value, or any payment made in compliance with the Political Reform Act of 1974 except a gift made under that act.

This bill would specify that a health care professional shall not be construed to include individuals employed by a manufacturer, working as a full-time contractor for a manufacturer or working as a full-time employee or contractor of a clinical research organization or business service firm, regardless of licensure, provided that the individual does not treat or otherwise render health care services to patients or hold a position to recommend prescribed products for a formulary, organization, or individuals.

This bill would define a health care provider as a health care professional, hospital, nursing home, pharmacist, health benefit plan administrator, hospital foundation that is organized as a nonprofit entity separate from a hospital, or any other person authorized to dispense, or purchase for distribution, prescribed products in California.

This bill would define a manufacturer as a pharmaceutical manufacturer, biological product manufacturer, or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repackaging, distributing, or labeling of prescribed products. This bill would specify that it does not include a wholesaler, a pharmacist, or a pharmacy.

This bill would expressly prohibit a manufacturer of a prescribed product from offering or giving a gift to a health care provider. This bill would also prohibit a manufacturer or an entity on behalf of a manufacturer from providing a fee, payment, subsidy, or other economic benefit, with the exception of allowable expenditures, to a health care provider in connection with the provider’s participation in research. This bill would specify that these prohibitions do not apply to the following:

- Samples of a prescribed product or reasonable quantities of an over-the-counter drug, an item of non-prescription durable medical equipment, an item of medical food as defined in federal law, or infant formula, that are provided to a health care provider for free distribution to patients.
- The provision, distribution, dissemination, or receipt of peer-reviewed academic, scientific, or other clinical articles or journals and other items that serve an educational function for the benefit of patients.

- Scholarship or other support for medical students, residents and fellows to attend a significant educational, scientific, or policy making conference or seminar.
- Rebates and discounts for prescribed products provided in the normal course of business.
- The provision to a free clinic of financial donations or of free prescription drugs, over-the-counter drugs, biological products, combination products, medical food or infant formula.
- Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.
- Fellowship salary support provided to fellows through grants from manufacturers of prescribed products, if the following apply: the grants are applied for by an academic institution or hospital or clinical research site; the institution, hospital or clinical research site selects the recipient fellows; the manufacturer imposes no further demands or limits on the use of the funds; and the fellowships are not named for a manufacturer, and no individual recipient's fellowship is attributed to a particular manufacturer.
- The provision of coffee or other snacks or refreshments at a booth at a conference or seminar.

Although the language was amended out of this bill that would have allowed the AG to bring an action seeking injunctive relief, costs, attorney's fees, and imposition of a civil penalty of up to \$10,000, the AG would still be responsible for enforcing the provisions of this bill and ensuring that manufacturers of prescribed products are not violating the restrictions in this bill.

This bill would state that it is the intent of the Legislature that the requirements and prohibitions in this bill would complement and operate in conjunction with the federal Physician Payments Sunshine Act. If the Physician Payments Sunshine Act is repealed or becomes inoperative, it is the intent of the Legislature to enact similar legislation requiring manufacturers to disclose payments or other transfers of value made to health care providers in California.

According to the author, studies have shown that interaction with the pharmaceutical industry is associated with substantially negative consequences that include risks to patient safety associated with unnecessary drug prescriptions, drug cost increases borne by the patient, less availability of generic drugs, and less attention paid to evidence-based prescribing. The author believes that the pervasive use of gifts is of special concern to vulnerable populations and that physicians prescribing in the California's foster care system in recent years have received, on average, more than twice the amount in payments and incentives from drug companies when compared with the typical California physician. The author introduced this bill because he believes the time has come for California to join the largest hospitals, eight other states and the District of Columbia in providing regulations on pharma gifts.

The Medical Board of California's (Board) primary mission is consumer protection. This bill would ensure that physicians are not influenced by gifts or economic benefits when deciding what brand of drug to prescribe, but would still allow for some

reasonable expenditures. This bill would further the Board's mission of consumer protection and the Board is supportive of this bill.

FISCAL: None to the Board

SUPPORT: AIDS Healthcare Foundation; California Health + Advocates; California Labor Federation; California Professional Firefighters; CALPIRG; Consumers Union; Health Access California; Medical Board of California; School Employers Association of California; and Small School Districts' Association

OPPOSITION: American College of Private Physicians
California Access Coalition
California Chapter of the American College of Cardiology
Infectious Disease Association of California
Sanofi

AMENDED IN ASSEMBLY JULY 6, 2017
AMENDED IN ASSEMBLY JUNE 22, 2017
AMENDED IN ASSEMBLY JUNE 13, 2017
AMENDED IN SENATE MAY 2, 2017
AMENDED IN SENATE APRIL 17, 2017
AMENDED IN SENATE MARCH 29, 2017

SENATE BILL

No. 790

**Introduced by Senator McGuire
(Coauthor: Senator Monning)**

February 17, 2017

An act to add Division 117 (commencing with Section 150300) to the Health and Safety Code, relating to health care providers.

LEGISLATIVE COUNSEL'S DIGEST

SB 790, as amended, McGuire. Health care providers: gifts and benefits.

The Sherman Food, Drug, and Cosmetic Law, administered by the State Department of Public Health, regulates the packaging, labeling, and advertising of drugs and devices, and requires a manufacturer of any drug or device in the state to be licensed by the department. Existing law imposes various requirements on persons engaged in the provision of health care services in the state.

This bill would, on and after January 1, 2019, prohibit a manufacturer of a prescribed product from offering or giving a gift to a health care provider. The bill would further prohibit a manufacturer of a prescribed product or an entity on behalf of a manufacturer of a prescribed product

from providing a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research, except as specified. The bill would define terms of its purposes, including, among others, the term "gift." The bill would specify circumstances to which these prohibitions do not apply.

Existing federal law, the Physician Payments Sunshine Act (Sunshine Act), requires manufacturers of specified drugs, devices, biologicals, or medical supplies to disclose to the federal Centers for Medicare and Medicaid Services payments or other transfers of value made to physicians or teaching hospitals.

This bill would state the intent of the Legislature that the prohibitions and requirements described above complement and operate in conjunction with the Sunshine Act. The bill would state the intent of the Legislature to enact legislation similar to the Sunshine Act if the Sunshine Act is repealed or becomes inoperative.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Division 117 (commencing with Section 150300)
2 is added to the Health and Safety Code, to read:

3
4 DIVISION 117. EXPENDITURES BY MANUFACTURERS
5 OF PRESCRIBED PRODUCTS

6
7 150300. For the purposes of this division, the following
8 definitions shall apply:

9 (a) "Allowable expenditure" means any of the following:

10 (1) Payment by a manufacturer of a prescribed product to the
11 sponsor of a significant educational, medical, scientific, or
12 policymaking conference or seminar, provided that all of the
13 following conditions are satisfied:

14 (A) The payment is not made directly to a health care
15 professional or pharmacist.

16 (B) Funding is used solely for bona fide educational purposes,
17 except that the sponsor may, in the sponsor's discretion, apply
18 some or all of the funding to provide meals and other food for all
19 conference participants.

1 (C) All program content is objective, free from industry control,
2 and does not promote specific products.

3 (2) Honoraria and payment of the expenses of a health care
4 professional who serves on the faculty at a bona fide educational,
5 medical, scientific, or policymaking conference or seminar, only
6 if all of the following conditions are satisfied:

7 (A) The honoraria or payment is governed by an explicit contract
8 with specific deliverables that are restricted to medical issues, not
9 marketing activities.

10 (B) Consistent with federal law, the content of the presentation,
11 including slides and written materials, is determined or at a
12 minimum is reviewed and approved by the health care professional.

13 (3) For a bona fide clinical trial or a research project that
14 constitutes a systematic investigation, is designed to develop or
15 contribute to general knowledge, and reasonably can be considered
16 to be of significant interest or value to scientists or health care
17 professionals working in the particular field of inquiry, all of the
18 following:

19 (A) Compensation for services provided by investigators, health
20 care professionals, or health care providers in connection with the
21 bona fide clinical trial or research project.

22 (B) Expenses paid on behalf of investigators, health care
23 professionals, or health care providers in connection with the bona
24 fide clinical trial or research project.

25 (C) Expenses paid by the investigators, health care professionals,
26 or health care providers in connection with the bona fide clinical
27 trial or research project.

28 (D) Materials and supplies used in connection with the bona
29 fide clinical trial or research project.

30 (4) Payment or reimbursement for reasonable expenses,
31 including travel and lodging-related expenses, necessary for
32 technical training of individual health care professionals on the
33 administration of a prescribed product, if the commitment to
34 provide those expenses and the amounts or categories of reasonable
35 expenses to be paid are described in a written agreement between
36 the health care provider and the manufacturer.

37 (5) Public health initiatives to develop replicable and sustainable
38 model programs that embody best practices in disease screening
39 and linkages to care.

(6) Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally recognized discovery for which the health care provider holds an ownership right. This also includes royalties, licensing fees, and financial transactions related to joint ventures and partnerships with health care providers.

(7) A payment to a health care provider for participation in bona fide marketing research conducted by a third party, only if the payments are made by that third party and the sponsoring manufacturer is not informed of the identity of the participating *health care* provider.

(8) Other reasonable fees, payments, subsidies, or other economic benefits provided by a manufacturer of a prescribed product at fair market value.

(9) The payment of reasonable expenses of an individual related to the interview of the individual by a manufacturer of prescribed products in connection with a bona fide employment opportunity or for health care services on behalf of an employee of the manufacturer.

(10) Provision of meals for a health care provider that do not exceed two hundred fifty dollars (\$250) per person, per year in value in addition to payments otherwise permitted under this subdivision.

(b) “Bona fide clinical trial” means an FDA-reviewed clinical trial that constitutes research as defined in Section 46.102 of Title 45 of the Code of Federal Regulations that can be reasonably considered to be of interest to scientists or health care professionals working in the particular field of inquiry.

(c) “Bona fide marketing research” means the collection and analysis of data regarding opinions, needs, awareness, knowledge, views, experiences, and behaviors of a population, through the development and administration of surveys, interviews, focus groups, polls, observation, or other research methodologies, in which no sales, promotional, or marketing efforts are involved and through which there is no attempt to influence a participant’s attitudes or behavior.

(d) “Clinical trial” means a study that does either of the following:

1 (1) Assesses the safety, efficacy, or effectiveness of prescribed
2 products administered alone or in combination with other
3 prescribed products or other therapies.

4 (2) Assesses the relative safety or efficacy of prescribed products
5 in comparison with other prescribed products or therapies.

6 (e) “Free clinic” means a health care facility operated by a
7 nonprofit private entity that satisfies all of the following conditions:

8 (1) In providing health care, the health care facility does not
9 accept reimbursement from any third-party payer, including
10 reimbursement from any insurance policy, health plan, or federal
11 or state health benefits program that is individually determined.

12 (2) In providing health care, the health care facility either does
13 not impose charges on patients to whom service is provided, or
14 imposes charges on patients according to their ability to pay.

15 (3) The health care facility may accept voluntary donations from
16 patients for the provision of health care services.

17 (4) The health care facility is licensed or certified to provide
18 health services under applicable law.

19 (f) “Gift” means a payment, food, entertainment, travel,
20 subscription, advance, service, or anything else of value provided
21 at no cost or less than full market value to a health care provider.
22 Notwithstanding the foregoing, “gift” does not include any
23 allowable expenditure as defined in subdivision (a), any payment,
24 food, entertainment, travel, subscription, advance, service, or
25 anything else of value for which the health care provider reimburses
26 the cost at fair market value, or any payment made in compliance
27 with the Political Reform Act of 1974 (Title 9 (commencing with
28 Section 81000) of the Government Code) except a gift made under
29 that act.

30 (g) “Health benefit plan administrator” means the person or
31 entity who sets formularies on behalf of an employer or health
32 insurer.

33 (h) (1) “Health care professional” means any of the following:

34 (A) A person who is authorized by law to prescribe or to
35 recommend prescribed products, who regularly practices in the
36 state, and who is either licensed by the state to provide or is
37 otherwise lawfully providing health care in the state.

38 (B) A partnership or corporation made up of the persons
39 described in subparagraph (A).

(C) An officer, employee, agent, or contractor of a person described in subparagraph (A). who is acting in the course and scope of employment, of an agency, or of a contract related to or supportive of the provision of health care to individuals.

(2) A “health care professional” shall not be construed to include individuals employed by a manufacturer, working as a full-time contractor for a manufacturer or working as a full-time employee or contractor of a clinical research organization or business services firm, regardless of licensure, provided that the individual does not treat or otherwise render health care services to patients or hold a position to recommend prescribed products for a formulary, organization, or individuals.

(i) “Health care provider” means a health care professional, hospital, nursing home, pharmacist, health benefit plan administrator, hospital foundation that is organized as a nonprofit entity separate from a hospital, or any other person authorized to dispense or purchase for distribution prescribed products in the state. A health care provider is not a veterinarian.

(j) “Investigator” means any individual who is involved in conducting a bona fide clinical trial or research project.

(k) “Manufacturer” means a pharmaceutical manufacturer, biological product manufacturer, or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repackaging, distributing, or labeling of prescribed products. “Manufacturer” does not include a wholesaler, as defined in Section 4043 of the Business and Professions Code, a pharmacist, as defined in Section 4036 of the Business and Professions Code, or a pharmacy, as defined in Section 4037 of the Business and Professions Code.

(l) “Marketing” means promoting, detailing, or any activity that is intended to be used or is used to influence sales or market share or to evaluate the effectiveness of a professional sales force.

(m) “Pharmaceutical manufacturer” means either of the following:

(1) An entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, whether directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis.

1 (2) An entity engaged in the packaging, repackaging, labeling,
2 relabeling, or distribution of prescription drugs.

3 (n) “Prescribed product” means a drug as defined in Section
4 321 of Title 21 of the United States Code, a compounded drug or
5 drugs, a biological product as defined in Section 262 of Title 42
6 of the United States Code for human use, or a combination product
7 as defined in subdivision (e) of Section 3.2 of Title 21 of the Code
8 of Federal Regulations.

9 (o) “Sample” means a unit of a prescription drug or biological
10 product that is not intended to be sold and is intended to promote
11 the sale of the drug or product and includes starter packs and
12 coupons or other vouchers that enable an individual to receive a
13 prescribed product free of charge or at a discounted price. “Sample”
14 does not include prescribed products distributed free of charge or
15 at a discounted price pursuant to a manufacturer-sponsored or
16 manufacturer-funded patient assistance program.

17 (p) “Research” or “research project” means a systematic
18 investigation, including research development, testing, and
19 evaluation, designed to develop or contribute to generalized
20 knowledge, whether or not it is conducted or supported under a
21 program that is considered research for other purposes.

22 (q) “Significant educational, scientific, or policymaking
23 conference or seminar” means a nonmarketing educational,
24 scientific, or policymaking conference or seminar that is national,
25 regional, or within the State of California and that satisfies either
26 of the following:

27 (1) The conference or seminar is accredited by the Accreditation
28 Council for Continuing Medical Education or a comparable
29 organization or is presented by an approved sponsor of continuing
30 education, only if the sole sponsor is not a manufacturer of
31 prescribed products.

32 (2) The conference or seminar offers continuing education credit,
33 features multiple presenters on scientific research, or is authorized
34 by the sponsor to recommend or make policy.

35 150302. A manufacturer of a prescribed product or an agent
36 thereof shall not offer or give a gift to a health care provider.

37 150304. Except as described in paragraph (3) of subdivision
38 (a) of Section 150300, a manufacturer or an entity on behalf of a
39 manufacturer shall not provide a fee, payment, subsidy, or other

1 economic benefit to a health care provider in connection with the
2 provider's participation in research.

3 150306. Sections 150302 and 150304 shall not apply to the
4 following:

5 (a) Samples of a prescribed product or reasonable quantities of
6 an over-the-counter drug, an item of medical food as defined in
7 Section 360ee of Title 21 of the United States Code, or infant
8 formula as defined in Section 321 of Title 21 of the United States
9 Code, that are provided to a health care provider for free
10 distribution to patients.

11 (b) The provision, distribution, dissemination, or receipt of
12 peer-reviewed academic, scientific, or clinical articles or journals
13 and other items that serve a genuine educational function provided
14 to a health care provider for the benefit of patients.

15 (c) Scholarship or other support for medical students, residents,
16 and fellows to attend a significant educational, scientific, or
17 policymaking conference or seminar of a national, regional, or
18 specialty medical or other professional association if the recipient
19 of the scholarship or other support is selected by the association.

20 (d) Rebates and discounts for prescribed products provided in
21 the normal course of business.

22 (e) The provision to a free clinic of financial donations or of
23 free prescription drugs, over-the-counter drugs, biological products,
24 combination products, medical food, or infant formula.

25 (f) Prescribed products distributed free of charge or at a
26 discounted price pursuant to a manufacturer-sponsored or
27 manufacturer-funded patient assistance program.

28 (g) Fellowship salary support provided to fellows through grants
29 ~~for~~ *from* manufacturers of prescribed products, provided that all
30 of the following conditions are satisfied:

31 (1) The grants are applied for by an academic institution or
32 hospital or clinical research site.

33 (2) The institution, hospital, or clinical research site selects the
34 recipient fellows.

35 (3) The manufacturer imposes no further demands or limits on
36 the institution's, hospital's, clinical research site's, or fellow's use
37 of the funds.

38 (4) Fellowships are not named for a manufacturer and no
39 individual recipient's fellowship is attributed to a particular
40 manufacturer of prescribed products.

1 (h) The provision of coffee or other snacks or refreshments at
2 a booth at a conference or seminar.

3 150308. It is the intent of the Legislature that the requirements
4 and prohibitions of this division complement and operate in
5 conjunction with the federal Physician Payments Sunshine Act
6 (42 U.S.C. Sec. 1320a-7h). If the Physician Payments Sunshine
7 Act is repealed or becomes inoperative, it is the intent of the
8 Legislature to enact similar legislation requiring manufacturers to
9 disclose payments or other transfers of value made to health care
10 providers in the state.

11 150310. This division shall become operative on January 1,
12 2019.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 796
Author: Hill
Bill Date: July 17, 2017, Amended
Subject: Uniform Standards: Naturopathic Doctors Act:
Respiratory Care Act
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill contains other provisions, including extending the sunset date for the Naturopathic Medicine Committee and the Respiratory Care Board; however, this analysis will only discuss the provision related to the Uniform Standards.

BACKGROUND:

SB 1441 (Chapter 548, Statutes of 2008) was authored by Senator Ridley-Thomas Chair of the Senate Business, Professions and Economic Development Committee. SB 1441 created the Substance Abuse Coordination Committee (SACC) subject to Bagley-Keene Open Meeting Act and required the committee, by January 1, 2010, to formulate uniform and specific standards in specified areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program. The Medical Board of California (Board) adopted its Uniform Standards in 2015 through the regulatory process.

SB 1177 (Galgiani, Chapter 591, Statutes of 2016) authorizes the establishment of a Physician and Surgeon Health and Wellness Program (PHWP) within the Board. The PHWP will provide for early identification of, and appropriate interventions to support a licensee in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety. The PHWP is required to provide for the education of all licensed physician and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems; offer assistance to a physician in identifying substance abuse problems; evaluate the extent of substance abuse problems and refer the physician to the appropriate treatment by executing a written agreement with the physician participant; provide for the confidential participation by a physician with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues; and comply with the Uniform Standards for Substance-Abusing Healing Arts Licensees as adopted by the SACC of the Department of Consumer Affairs (DCA) pursuant to Business and Professions Code Section 315.

SB 1177 authorizes the Board to contract with a private third-party independent administering entity to administer the program that must meet specified requirements and must have a system for immediately reporting a physician from the program to the Board, including but not limited to, a physician who withdraws or is terminated.

ANALYSIS

This bill would require DCA's SACC to review the existing criteria for Uniform Standard #4, which is regarding substance testing. Specifically, Uniform Standard #4 governs all aspects of required testing, including, but not limited to, frequency of testing, randomicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

This bill would require the SACC to review the criteria and make findings to determine whether the existing criteria for Uniform Standard #4 should be updated to reflect recent developments in testing research and technology. This bill would require the SACC to consider information from, but not limited to, the American Society of Addiction Medicine, and other sources of best practice.

The Board already adopted the Uniform Standards in 2015. However, with passage of SB 1177 from 2016, the Board is now working to develop the PHWP. The PHWP is required to meet all the Uniform Standards. Board staff agrees that Uniform Standard #4 should be reviewed to reflect recent developments in testing research and technology and suggests that the Board support this provision in the bill.

FISCAL: None to the Board

SUPPORT: Bastyr University; California Naturopathic Doctors Association; Respiratory Care Board of California; Naturopathic Medicine Committee; Southern California University of Health Sciences; State of Utah Division of Occupational and Professional Licensing; and State of Washington Board of Naturopathy

OPPOSITION: American Naturopathic Medical Association; California Health Freedom Coalition; California Naturopathic Association; Natural Health Freedom Action; Natural Healing Institute of Naturopathy, Inc.; Sunshine Health Freedom Foundation; and Numerous individuals

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY JULY 17, 2017

AMENDED IN ASSEMBLY JULY 3, 2017

AMENDED IN SENATE MAY 26, 2017

AMENDED IN SENATE APRIL 17, 2017

SENATE BILL

No. 796

Introduced by Senator Hill

February 17, 2017

An act to amend Sections 315, 2450.3, 3621, 3623, 3630, 3635, 3644, 3660, 3680, 3686, 3710, 3716, and 3772 of, to add Sections 3635.1 and 3635.2 to, and to repeal Section 3645 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 796, as amended, Hill. Uniform Standards: Naturopathic Doctors Act: Respiratory Care Practice Act.

(1) The Department of Consumer Affairs is comprised of healing arts boards that are responsible for the licensure and regulation of healing arts licensees. Under existing law, the Substance Abuse Coordination Committee is created within the department and the committee is required to formulate uniform and specific standards in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees. Existing law, by January 1, 2010, requires the committee to formulate uniform and specific standards in specified areas, including standards governing all aspects of required testing, that each healing arts board is required to use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program.

This bill, by January 1, 2019, would require the committee to review the existing criteria for those standards governing all aspects of required testing to determine whether the existing criteria should be updated to reflect recent developments in testing research and technology.

(2) Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee within the Osteopathic Medical Board of California for the licensure and regulation of naturopathic doctors. Existing law requires the committee to consist of 9 members appointed by the Governor, including 2 public members. Existing law requires a public member to be a citizen of the state for at least 5 years preceding his or her appointment.

This bill would instead require 7 professional members to be appointed by the Governor, one public member to be appointed by the Senate Committee on Rules, and one public member to be appointed by the Speaker of the Assembly. The bill would instead require a public member to be a resident of the state for at least 5 years preceding his or her appointment.

Existing law repeals the act on January 1, 2018. Existing law also specifies that the committee is subject to review by the appropriate policy committees of the Legislature on January 1, 2018.

This bill would instead repeal the act and subject the committee to legislative review on January 1, 2022.

Existing law requires an applicant for a license as a naturopathic doctor to file a written application with the committee, as specified. Existing law requires the committee to establish the amount of the fee assessed to conduct activities of the committee, including the amount of fees for applicant licensure, licensure renewal, late renewal, and childbirth certification. Existing law requires the committee to require the satisfactory completion of 60 hours of approved continuing education biennially, as specified, for licensure renewal.

This bill would remove the requirement that an application be written. The bill would specify the amount or maximum amount for each of the fees. The bill would require a licensee to retain certificates of continuing education course completion for 6 years. The bill would authorize the committee to audit licensees' continuing education records to ensure that continuing education requirements are met. The bill would specify that furnishing false or misleading information to the committee regarding continuing education constitutes unprofessional conduct.

Existing law requires the committee to approve a specified naturopathic medical education program. Existing law requires boards

within the Department of Consumer Affairs to adopt rules and regulations to provide for methods of evaluating education, training, and experience obtained in the armed services, if applicable to the requirements of the business, occupation, or profession regulated, and to specify how this education, training, and experience may be used to meet the licensure requirements for the particular business, occupation, or profession regulated. Existing law also requires these boards to consult with the Department of Veterans Affairs and the Military Department before adopting these rules and regulations.

This bill would require that the naturopathic medical program, pursuant to those provisions, evaluate an applicant's education, training, and experience obtained in the armed services, and provide course credit where applicable.

Existing law requires the satisfactory completion of specified hours of approved continuing education biennially in order to renew a license. Existing law requires the continuing education to meet certain requirements *and* to be provided by an approved continuing education provider.

This bill would additionally require the course content to pertain to the practice of naturopathic, osteopathic, or allopathic medicine. The bill would require continuing education providers to comply with certain conflict-of-interest requirements. The bill would also require these providers to submit a related annual declaration to the committee. The bill would require the committee to maintain a list of these providers meeting those requirements on its Internet Web site.

Existing law does not prevent or restrict the practice, services, or activities of a person who makes recommendations regarding or is engaged in the sale of, among other things, food or vitamins.

This bill would authorize an unlicensed person to represent that he or she "practices naturopathy" if certain requirements *related to restrictions on services provided and specified disclosures and acknowledgments* are met.

Existing law requires that a person be licensed to use the professional abbreviation "N.D." or other titles, words, letters, or symbols with the intent to represent that he or she practices, is authorized to practice, or is able to practice naturopathic medicine as a naturopathic doctor, except as specified. Existing law makes a violation of this provision a crime. Existing law also specifies that the Naturopathic Doctors Act permits, and does not restrict the use of, the titles "naturopath," "naturopathic practitioner," and "traditional naturopathic practitioner" by persons

who are educated and trained for those positions. Existing law specifies that the Naturopathic Doctors Act permits, and does not restrict, the education of these persons, and does not require these persons to be licensed under the act.

This bill would repeal the provisions restricting the scope of the act, and instead would require that a person be licensed to use the title “naturopath,” “naturopathic practitioner,” or “traditional naturopathic practitioner” with the intent to represent that he or she practices, is authorized to practice, or is able to practice naturopathic medicine as a naturopathic doctor, except as specified. Until January 1, 2020, the bill would authorize the use of the terms “naturopath,” “naturopathic practitioner,” and “traditional naturopathic practitioner” to be used in certain materials by persons who are educated and trained, but not licensed, to practice naturopathy pursuant to this act. By expanding the definition of a crime, this bill would impose a state-mandated local program. *instead would specify that the Naturopathic Doctors Act permits, and does not restrict, the use of those titles by persons who are educated and trained for those positions and who comply with requirements related to restrictions on services provided and specified disclosures and acknowledgments.*

(3) Existing law, the Respiratory Care Practice Act, establishes the Respiratory Care Board of California for the licensure and regulation of respiratory care practitioners. Existing law specifies that the board is subject to review by the appropriate policy committees of the Legislature upon repeal of the provision establishing the board. Existing law also authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2018.

This bill would instead repeal those provisions on January 1, 2022.

Existing law establishes the Respiratory Care Fund in the State Treasury to carry out the purposes of the act, and requires all collections from persons licensed or seeking to be licensed under the Respiratory Care Act to be paid into the fund, as specified.

This bill would make the availability of the moneys in the fund contingent upon appropriation by the Legislature.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 315 of the Business and Professions Code
2 is amended to read:
3 315. (a) For the purpose of determining uniform standards
4 that will be used by healing arts boards in dealing with
5 substance-abusing licensees, there is established in the Department
6 of Consumer Affairs the Substance Abuse Coordination
7 Committee. The committee shall be comprised of the executive
8 officers of the department's healing arts boards established pursuant
9 to Division 2 (commencing with Section 500), the State Board of
10 Chiropractic Examiners, the Osteopathic Medical Board of
11 California, and a designee of the State Department of Health Care
12 Services. The Director of Consumer Affairs shall chair the
13 committee and may invite individuals or stakeholders who have
14 particular expertise in the area of substance abuse to advise the
15 committee.
16 (b) The committee shall be subject to the Bagley-Keene Open
17 Meeting Act (Article 9 (commencing with Section 11120) of
18 Division 3 of Title 2 of the Government Code).
19 (c) By January 1, 2010, the committee shall formulate uniform
20 and specific standards in each of the following areas that each
21 healing arts board shall use in dealing with substance-abusing
22 licensees, whether or not a board chooses to have a formal
23 diversion program:
24 (1) Specific requirements for a clinical diagnostic evaluation of
25 the licensee, including, but not limited to, required qualifications
26 for the providers evaluating the licensee.
27 (2) Specific requirements for the temporary removal of the
28 licensee from practice, in order to enable the licensee to undergo
29 the clinical diagnostic evaluation described in paragraph (1) and
30 any treatment recommended by the evaluator described in
31 paragraph (1) and approved by the board, and specific criteria that
32 the licensee must meet before being permitted to return to practice
33 on a full-time or part-time basis.

1 (3) Specific requirements that govern the ability of the licensing
2 board to communicate with the licensee's employer about the
3 licensee's status and condition.

4 (4) Standards governing all aspects of required testing, including,
5 but not limited to, frequency of testing, randomness, method of
6 notice to the licensee, number of hours between the provision of
7 notice and the test, standards for specimen collectors, procedures
8 used by specimen collectors, the permissible locations of testing,
9 whether the collection process must be observed by the collector,
10 backup testing requirements when the licensee is on vacation or
11 otherwise unavailable for local testing, requirements for the
12 laboratory that analyzes the specimens, and the required maximum
13 timeframe from the test to the receipt of the result of the test.

14 (5) Standards governing all aspects of group meeting attendance
15 requirements, including, but not limited to, required qualifications
16 for group meeting facilitators, frequency of required meeting
17 attendance, and methods of documenting and reporting attendance
18 or nonattendance by licensees.

19 (6) Standards used in determining whether inpatient, outpatient,
20 or other type of treatment is necessary.

21 (7) Worksite monitoring requirements and standards, including,
22 but not limited to, required qualifications of worksite monitors,
23 required methods of monitoring by worksite monitors, and required
24 reporting by worksite monitors.

25 (8) Procedures to be followed when a licensee tests positive for
26 a banned substance.

27 (9) Procedures to be followed when a licensee is confirmed to
28 have ingested a banned substance.

29 (10) Specific consequences for major violations and minor
30 violations. In particular, the committee shall consider the use of a
31 "deferred prosecution" stipulation similar to the stipulation
32 described in Section 1000 of the Penal Code, in which the licensee
33 admits to self-abuse of drugs or alcohol and surrenders his or her
34 license. That agreement is deferred by the agency unless or until
35 the licensee commits a major violation, in which case it is revived
36 and the license is surrendered.

37 (11) Criteria that a licensee must meet in order to petition for
38 return to practice on a full-time basis.

39 (12) Criteria that a licensee must meet in order to petition for
40 reinstatement of a full and unrestricted license.

1 (13) If a board uses a private-sector vendor that provides
2 diversion services, standards for immediate reporting by the vendor
3 to the board of any and all noncompliance with any term of the
4 diversion contract or probation; standards for the vendor's approval
5 process for providers or contractors that provide diversion services,
6 including, but not limited to, specimen collectors, group meeting
7 facilitators, and worksite monitors; standards requiring the vendor
8 to disapprove and discontinue the use of providers or contractors
9 that fail to provide effective or timely diversion services; and
10 standards for a licensee's termination from the program and referral
11 to enforcement.

12 (14) If a board uses a private-sector vendor that provides
13 diversion services, the extent to which licensee participation in
14 that program shall be kept confidential from the public.

15 (15) If a board uses a private-sector vendor that provides
16 diversion services, a schedule for external independent audits of
17 the vendor's performance in adhering to the standards adopted by
18 the committee.

19 (16) Measurable criteria and standards to determine whether
20 each board's method of dealing with substance-abusing licensees
21 protects patients from harm and is effective in assisting its licensees
22 in recovering from substance abuse in the long term.

23 (d) Notwithstanding any other law, by January 1, 2019, the
24 committee shall review the existing criteria for Uniform Standard
25 #4 established pursuant to paragraph (4) of subdivision (c). The
26 committee's review and findings shall determine whether the
27 existing criteria for Uniform Standard #4 should be updated to
28 reflect recent developments in testing research and technology.
29 The committee shall consider information from, but not limited
30 to, the American Society of Addiction Medicine, and other sources
31 of best practices.

32 SEC. 2. Section 2450.3 of the Business and Professions Code
33 is amended to read:

34 2450.3. There is within the jurisdiction of the Osteopathic
35 Medical Board of California a Naturopathic Medicine Committee
36 authorized under the Naturopathic Doctors Act (Chapter 8.2
37 (commencing with Section 3610)). This section shall become
38 inoperative on January 1, 2022, and as of that date is repealed.
39 Notwithstanding any other provision of law, the repeal of this

1 section renders the Naturopathic Medicine Committee subject to
2 review by the appropriate policy committees of the Legislature.

3 SEC. 3. Section 3621 of the Business and Professions Code is
4 amended to read:

5 3621. (a) The committee shall consist of nine members,
6 consisting of seven professional members appointed by the
7 Governor, one public member appointed by the Senate Committee
8 on Rules, and one public member appointed by the Speaker of the
9 Assembly. Members of the committee shall include five members
10 who are California licensed naturopathic doctors, two members
11 who are California licensed physicians and surgeons, and two
12 public members.

13 (b) A member of the committee shall be appointed for a
14 four-year term. A person shall not serve as a member of the
15 committee for more than two consecutive terms. A member shall
16 hold office until the appointment and qualification of his or her
17 successor, or until one year from the expiration of the term for
18 which the member was appointed, whichever first occurs.
19 Vacancies shall be filled by appointment for unexpired terms.

20 (c) (1) A public member of the committee shall be a resident
21 of this state for at least five years preceding his or her appointment.

22 (2) A person shall not be appointed as a public member if the
23 person or the person's immediate family in any manner owns an
24 interest in a college, school, or institution engaged in naturopathic
25 education, or the person or the person's immediate family has an
26 economic interest in naturopathy or has any other conflict of
27 interest. "Immediate family" means the public member's spouse,
28 parents, children, or his or her children's spouses.

29 (d) Each member of the committee shall receive a per diem and
30 expenses as provided in Section 103.

31 (e) The committee may appoint a person exempt from civil
32 service who shall be designated as an executive officer and who
33 shall exercise the powers and perform the duties delegated by the
34 committee and vested in him or her by this chapter.

35 SEC. 4. Section 3623 of the Business and Professions Code is
36 amended to read:

37 3623. (a) The committee shall approve a naturopathic medical
38 education program accredited by the Council on Naturopathic
39 Medical Education or an equivalent federally recognized

1 accrediting body for the naturopathic medical profession that has
2 the following minimum requirements:

3 (1) Admission requirements that include a minimum of
4 three-quarters of the credits required for a bachelor's degree from
5 a regionally accredited or preaccredited college or university or
6 the equivalency, as determined by the council.

7 (2) Program requirements for its degree or diploma of a
8 minimum of 4,100 total hours in basic and clinical sciences,
9 naturopathic philosophy, naturopathic modalities, and naturopathic
10 medicine. Of the total requisite hours, not less than 2,500 hours
11 shall consist of academic instruction, and not less than 1,200 hours
12 shall consist of supervised clinical training approved by the
13 naturopathic medical school.

14 (b) A naturopathic medical education program in the United
15 States shall offer graduate-level full-time studies and training
16 leading to the degree of Doctor of Naturopathy or Doctor of
17 Naturopathic Medicine. The program shall be an institution, or
18 part of an institution of, higher education that is either accredited
19 or is a candidate for accreditation by a regional institutional
20 accrediting agency recognized by the United States Secretary of
21 Education and the Council on Naturopathic Medical Education,
22 or an equivalent federally recognized accrediting body for
23 naturopathic doctor education.

24 (c) To qualify as an approved naturopathic medical school, a
25 naturopathic medical program located in Canada or the United
26 States shall offer a full-time, doctoral-level, naturopathic medical
27 education program with its graduates being eligible to apply to the
28 committee for licensure and to the North American Board of
29 Naturopathic Examiners that administers the naturopathic licensing
30 examination.

31 (d) The naturopathic medical program shall evaluate an
32 applicant's education, training, and experience obtained in the
33 armed services, pursuant to Section 35, and provide course credit
34 where applicable.

35 SEC. 5. Section 3630 of the Business and Professions Code is
36 amended to read:

37 3630. An applicant for a license as a naturopathic doctor shall
38 file an application with the committee on a form provided by the
39 committee that shows, to the committee's satisfaction, compliance
40 with all of the following requirements:

1 (a) The applicant has not committed an act or crime that
2 constitutes grounds for denial of a license under Section 480, and
3 has complied with the requirements of Section 144.

4 (b) The applicant has received a degree in naturopathic medicine
5 from an approved naturopathic medical school where the degree
6 substantially meets the educational requirements in paragraph (2)
7 of subdivision (a) of Section 3623.

8 SEC. 6. Section 3635 of the Business and Professions Code is
9 amended to read:

10 3635. (a) In addition to any other qualifications and
11 requirements for licensure renewal, the committee shall require
12 the satisfactory completion of 60 hours of approved continuing
13 education biennially. This requirement is waived for the initial
14 license renewal. The continuing education shall meet the following
15 requirements:

16 (1) At least 20 hours shall be in pharmacotherapeutics.

17 (2) No more than 15 hours may be in naturopathic medical
18 journals or osteopathic or allopathic medical journals, or audio or
19 videotaped presentations, slides, programmed instruction, or
20 computer-assisted instruction or preceptorships.

21 (3) No more than 20 hours may be in any single topic.

22 (4) No more than 15 hours of the continuing education
23 requirements for the specialty certificate in naturopathic childbirth
24 attendance shall apply to the 60 hours of continuing education
25 requirement.

26 (5) Course content shall pertain to the practice of naturopathic,
27 osteopathic, or allopathic medicine.

28 (b) The continuing education requirements of this section may
29 be met through continuing education courses approved by the
30 committee, the California Naturopathic Doctors Association, the
31 American Association of Naturopathic Physicians, the California
32 State Board of Pharmacy, the State Board of Chiropractic
33 Examiners, or other courses that meet the standards for continuing
34 education for licensed physicians and surgeons in California. All
35 continuing education providers shall comply with Section 3635.2.
36 Continuing education providers shall submit an annual declaration
37 to the committee that their educational activities satisfy the
38 requirements described in Section 3635.2 and the committee shall
39 maintain a list of these providers on its Internet Web site.

1 SEC. 7. Section 3635.1 is added to the Business and Professions
2 Code, to read:

3 3635.1. (a) A licensee shall retain certificates of continuing
4 education course completion for six years.

5 (b) The committee may audit licensees' continuing education
6 records to ensure that continuing education requirements are met.

7 (c) It shall be unprofessional conduct for a licensee to furnish
8 false or misleading information to the committee regarding
9 continuing education.

10 SEC. 8. Section 3635.2 is added to the Business and Professions
11 Code, to read:

12 3635.2. In addition to complying with subdivision (b) of
13 Section 3635, the following shall apply to providers of continuing
14 education:

15 (a) The content of continuing education courses and related
16 materials shall provide balance, independence, objectivity, and
17 scientific rigor. All patient care recommendations from continuing
18 education courses involving clinical medicine shall be based on
19 evidence accepted by naturopathic doctors. All scientific research
20 used to support patient care recommendations shall conform to
21 generally accepted standards of experimental design, data
22 collection, and analysis.

23 (b) A conflict of interest is created when an individual in a
24 position to control the content of a continuing education course,
25 or his or her spouse or partner, has a relevant personal financial
26 relationship within the past 12 months with a commercial entity
27 that produces, markets, resells, or distributes health care goods or
28 services consumed by, or used on patients that benefits the
29 individual in any financial amount and therefore, may bias his or
30 her opinions and teachings with respect to the content of continuing
31 education courses. This may include receiving a salary, royalty,
32 intellectual property rights, consulting fee, honoraria, ownership
33 interest such as stocks, stock options or other ownership interest,
34 excluding diversified mutual funds, or other financial benefit.
35 Financial benefits are generally associated with roles such as
36 employment, a management position, or an independent contractor
37 position, including contracted research and clinical trials,
38 consulting, speaking and teaching, membership on advisory
39 committees or review panels, board membership, and other
40 activities for which remuneration is received or expected.

1 (c) Prior to a course being presented, continuing education
2 providers shall identify, disclose, and resolve all conflicts of
3 interest. Individuals who fail or refuse to disclose relevant financial
4 relationships shall not be approved as a provider of continuing
5 education as described in subdivision (b) of Section 3635.

6 (d) Conflicts of interests shall be resolved by one of the
7 following mechanisms:

8 (1) Altering financial relationships. Individuals may change
9 their relationships with commercial interests, such as
10 discontinuance of contracted services, thereby eliminating any
11 conflict of interest related to the continuing education content.

12 (2) Altering control over content. An individual's control of
13 continuing education content may be altered in several ways to
14 remove the opportunity to affect content related to the products
15 and services of a commercial interest. These include the following:

16 (A) Choose someone else to control that part of the content. If
17 a proposed presenter or planner has a conflict of interest related
18 to the content, someone else who does not have a relationship to
19 the commercial interests related to the content may present or plan
20 that part of the content.

21 (B) Change the focus of the continuing education activity so
22 that the content is not about products or services of the commercial
23 interest that is the basis of the conflict of interest.

24 (C) Change the content of the individual's assignment so that
25 it is no longer about products or services of the commercial interest.
26 For example, an individual with a conflict of interest regarding
27 products for treatment of a condition could address the
28 pathophysiology or diagnosis of the condition, rather than
29 therapeutics.

30 (D) Limit the content to a report without recommendations. If
31 an individual has been funded by a commercial entity to perform
32 research, the individual's presentation may be limited to the data
33 and results of the research. Someone else may be assigned to
34 address broader implications and recommendations.

35 (E) Limit the sources for recommendations. Rather than having
36 a person with a conflict of interest present personal
37 recommendations or personally select the evidence to be presented,
38 limit the role of the person to reporting recommendations based
39 on formal structured reviews of the literature with the inclusion
40 and exclusion criteria stated "evidence-based."

1 (3) Conflict of interest may be resolved if the continuing
2 education material is peer reviewed and both of the following are
3 met:

4 (A) All the recommendations involving clinical medicine are
5 based on evidence that is accepted within the profession of
6 naturopathic medicine as adequate justification for indications and
7 contraindications in the care of patients.

8 (B) All scientific research referred to, reported, or used in the
9 continuing education activity in support or justification of patient
10 care recommendations conforms to the generally accepted standards
11 of experimental design, data collection, and analysis.

12 SEC. 9. Section 3644 of the Business and Professions Code is
13 amended to read:

14 3644. This chapter does not prevent or restrict the practice,
15 services, or activities of any of the following:

16 (a) A person licensed, certified, or otherwise recognized in this
17 state by any other law or regulation if that person is engaged in
18 the profession or occupation for which he or she is licensed,
19 certified, or otherwise recognized.

20 (b) A person employed by the federal government in the practice
21 of naturopathic medicine while the person is engaged in the
22 performance of duties prescribed by laws and regulations of the
23 United States.

24 (c) A person rendering aid to a family member or in an
25 emergency, if no fee or other consideration for the service is
26 charged, received, expected, or contemplated.

27 (d) (1) A person who makes recommendations regarding or is
28 engaged in the sale of food, extracts of food, nutraceuticals,
29 vitamins, amino acids, minerals, enzymes, botanicals and their
30 extracts, botanical medicines, homeopathic medicines, dietary
31 supplements, and nonprescription drugs or other products of nature,
32 the sale of which is not otherwise prohibited under state or federal
33 law.

34 (2) An unlicensed person described in this subdivision may
35 represent that he or she “practices naturopathy” if he or she
36 complies with Section 2053.6. However, an unlicensed person
37 may not use the title “naturopathic doctor” unless he or she has
38 been issued a license by the committee.

(e) A person engaged in good faith in the practice of the religious tenets of any church or religious belief without using prescription drugs.

(f) A person acting in good faith for religious reasons as a matter of conscience or based on a personal belief, while obtaining or providing information regarding health care and the use of any product described in subdivision (d).

(g) A person who provides the following recommendations regarding the human body and its function:

(1) Nonprescription products.

(2) Natural elements such as air, heat, water, and light.

(3) Class I or class II nonprescription, approved medical devices, as defined in Section 360c of Title 21 of the United States Code.

(4) Vitamins, minerals, herbs, homeopathics, natural food products and their extracts, and nutritional supplements.

(h) A person who is licensed in another state, territory, or the District of Columbia to practice naturopathic medicine if the person is incidentally called into this state for consultation with a naturopathic doctor.

(i) A student enrolled in an approved naturopathic medical program whose services are performed pursuant to a course of instruction under the supervision of a naturopathic doctor.

~~SEC. 10. Section 3645 of the Business and Professions Code is repealed.~~

SEC. 10. Section 3645 of the Business and Professions Code is amended to read:

3645. (a) This chapter permits, and does not ~~restrict~~ *restrict*, the use ~~of~~, *of* the following titles by persons who *comply with subdivision (c) and* are educated and trained as any of the following:

(1) “Naturopath.”

(2) “Naturopathic practitioner.”

(3) “Traditional naturopathic practitioner.”

(b) This chapter permits, and does not restrict, the education of persons as described in paragraphs (1) to (3), inclusive, of subdivision (a). Those persons are not required to be licensed under this chapter.

(c) *An unlicensed person may use the titles specified in subdivision (a) if the unlicensed person does all of the following:*

(1) *Complies with Section 2053.6.*

1 (2) *Provides a conspicuous disclosure in all marketing,*
2 *advertisements, and other related materials that states, in plain*
3 *language, that the person is not licensed by the Naturopathic*
4 *Medicine Committee as a naturopathic doctor.*

5 (3) *Obtains verbal confirmation that the client understands that*
6 *the person is not licensed as a naturopathic doctor prior to*
7 *providing advice or arranging for services related to the practice*
8 *of naturopathy over the phone.*

9 SEC. 11. Section 3660 of the Business and Professions Code
10 is amended to read:

11 3660. Except as provided in subdivision (h) of Section 3644,
12 a person shall have a valid, unrevoked, or unsuspended license
13 issued under this chapter to do any of the following:

14 (a) To claim to be a naturopathic doctor, licensed naturopathic
15 doctor, doctor of naturopathic medicine, doctor of naturopathy, or
16 naturopathic medical doctor.

17 (b) To use the professional designation “N.D.,” “naturopath,”
18 ~~“naturopathic practitioner,” “traditional naturopathic practitioner,”~~
19 “N.D.” or other titles, words, letters, or symbols with the intent
20 to represent that he or she practices, is authorized to practice, or
21 is able to practice naturopathic medicine as a naturopathic doctor.

22 ~~(c) Until January 1, 2020, the use of the terms “naturopath,”~~
23 ~~“naturopathic practitioner,” and “traditional naturopathic~~
24 ~~practitioner” may be used in marketing, advertisements, and other~~
25 ~~related materials by persons who are educated and trained, but not~~
26 ~~licensed, to practice naturopathy pursuant to this chapter.~~
27 ~~Individuals shall not be disciplined for the misuse of titles not~~
28 ~~under their control.~~

29 SEC. 12. Section 3680 of the Business and Professions Code
30 is amended to read:

31 3680. (a) The application fee for a doctor of naturopathic
32 medicine shall be no more than four hundred dollars (\$400).

33 (b) The initial license fee shall be no more than eight hundred
34 dollars (\$800).

35 (c) The renewal fee for a license shall be no more than eight
36 hundred dollars (\$800).

37 (d) The late renewal fee for a license shall be no more than one
38 hundred fifty dollars (\$150).

39 (e) The fee for processing fingerprint cards shall be the current
40 fee charged by the Department of Justice.

(f) The fee for a duplicate or replacement license shall be no more than twenty-five dollars (\$25).

SEC. 13. Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 14. Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) This section shall remain in effect only until January 1, 2022, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 15. Section 3716 of the Business and Professions Code is amended to read:

3716. (a) The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

(b) This section shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 16. Section 3772 of the Business and Professions Code is amended to read:

3772. There is established in the State Treasury the Respiratory Care Fund. All collections from persons licensed or seeking to be licensed under this chapter shall be paid by the board into the fund after the report to the Controller at the beginning of each month of the amount and source of the collections. Moneys in the fund shall be available to the board, upon appropriation by the Legislature.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California
2 Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 798
Author: Hill
Bill Date: July 6, 2017, Amended
Subject: Healing Arts: Boards
Sponsor: Author
Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This is the Medical Board of California's (Board) sunset bill, which includes language on a portion of the new issues from the Board's 2016 Sunset Review Report, and will extend the Board's sunset date for four years, until January 1, 2022.

There are some issues that are included in this bill that are not issues raised in the Board's sunset report. This bill would allow the Board to recover costs for investigations and prosecutions for disciplinary proceedings. This bill would require specified physicians to notify patients that they are on probation and would require the Board to post specified information on the physician's profile on the Board's website. This bill would include licensed midwives (LMs) in the peer review sections and the medical corporation law. This bill would allow a doctor of podiatric medicine (DPM) to recommend medical cannabis. Lastly this bill would include intent language regarding the vertical enforcement and prosecution model.

ANALYSIS:

The Board included new issues in its 2016 Sunset Review Report to the Legislature. This report was submitted to the Legislature and the Legislature prepared a background paper that raised 30 issues, some of them related to the new issues included in the Board's Sunset Review Report. Here are the new issues that were included in the Board's Sunset Review Report and are included in this bill:

- Allow the Board to issue a two-year license to its licensees, instead of using a physician's birth date to calculate license expiration dates – **Due to a drafting error, this bill does not include language for a two-year license for all of the Board's licensees, but this language will likely be included soon. It does include technical language to clean-up existing law related to licensing fees for licensees not under the purview of the Board.**
- Change the postgraduate training requirement from one or two years to three years for all applicants, regardless of where they went to medical school. Create a postgraduate training license to allow an individual in a postgraduate training program to continue in that program without violating the law. Delete the requirement for the Board to

approve international medical schools. - **This bill includes language that would require an applicant to complete three years of postgraduate training in order to be eligible for licensure. This bill includes some exceptions for applicants who have a medical degree from a combined dental and medical degree program. This bill would create a postgraduate training license with specified application requirements that must be obtained within 180 days after enrollment in a postgraduate training program and would be valid until 90 days after the holder has completed 36 months of postgraduate training. This bill would delete the requirement for the Board to approve international medical schools. This bill would determine that an international medical school is recognized if they are listed on the World Federation for Medical Education and the Foundation for Advancement of International Medical Education and Research World Directory of Medical Schools joint directory or the World Directory of Medical Schools.**

- Require data reporting for accredited outpatient settings and revise the adverse events that outpatient settings are required to report to the Board. - **This bill includes language largely based on what was included in previous legislation and existing law regarding data that surgical clinics are required to report to OSHPD. This bill would also revise the adverse events that are required to be reported to the Board in existing law to only include those that relate to outpatient settings.**
- Amend existing law to allow the Board to require more information about the Board in a more consumer friendly manner on notice to consumers' postings. – **This bill adds Business and Professions Code (BPC) Section 2026 to allow the Board to require changes and more information in the notice to consumers posting.**
- Amend BPC Code section 805.01 to allow the Board to fine an entity up to \$50,000 per violation for failing to submit an 805.01 report to the Board, or \$100,000 per violation if it is determined that the failure to report was willful.– **This bill includes this language.**
- Require state agencies and hospital accrediting agencies to report to the Board any peer review incidents subject to 805 reporting that are found during an inspection of a health care facility or clinic. – **This bill no longer includes this language, concerns were raised by the California Hospital Association.**
- Amend existing law regarding the Health Professions Education Foundation (HPEF) to require two members to be appointed by the Board, as was previously required. –**This bill includes this language.**
- The Board recommended in its previous sunset report that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and any additional boards

previously approved by the Board. – **This bill includes this language.**

- Make technical, clarifying changes to make it clear that the Board of Podiatric Medicine (BPM) is its own board that performs its own licensing functions. – **This bill includes this language.**
- Delete the requirement in existing law that the Board president cannot be on a disciplinary panel. – **This bill includes this language.**
- Amend existing law regarding the prompt revocation of physicians who are required to register as sex offenders, and change it to an automatic revocation to allow the revocations to be processed in a more expeditious manner. – **This bill includes this language.**
- Amend BPC Section 2225 to make it clear that invocation of the psychotherapist-patient privilege is not a barrier to the Board obtaining psychotherapy records via a subpoena upon a showing of good cause. – **This bill currently includes this language.**
- Allow the Board to issue a cease practice order in cases where a licensee delays or does not comply with an order to undergo a physical or mental health examination. – **This bill includes this language.**
- Amend existing law related to expert witness reports, to include additional information that the reports must include and to ensure the Board receives these reports in a timely manner. – **This bill currently includes this language.**
- Existing law, Government Code Section 11529 requires that if the Board pursues and obtains an Interim Suspension Order (ISO), it has 30 days to file an accusation. A petition to revoke probation is very similar to an accusation in that it is still the charging document identifying what the physician has done to violate the law. The Board is recommending an amendment to add petitions to revoke probation. – **This bill includes this language.**
- Delete outdated sections of law related to the Board's Licensing Program. – **This bill repeals these outdated sections.**

There some issues that are included in this bill that are not issues raised in the Board's sunset report. They are as follows:

This bill would have required, on and after July 1, 2018, the Board to require all licensees on probation, pursuant to a probationary order made on or after July 1, 2018, before a patient's first visit following the probationary order, to provide the patient or the patient's guardian or health care surrogate, with a separate disclosure containing all the following information:

- The licensee's probationary status.

- The length of the probation and the end date.
- All practice restrictions placed on the licensee by the Board.
- The Board's telephone number.
- An explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the Board's online license information site.

However, at the last meeting the Board requested amendments related to probation notification to narrow the types of cases that require patient notification. These amendments were taken by the author and the bill now only requires patient notification on an after July 1, 2018, as specified above, in any of the following circumstances:

- The legal conclusions of an administrative law judge find or in a stipulated settlement the licensee admits, or if no admissions, the accusation or the statement of issues charges, that the licensee is implicated in any of the following:
 - Sexual misconduct.
 - Drug or alcohol abuse during practice.
 - Criminal conviction involving the practice of medicine.
- If the licensee has previously surrendered his or her license, had his or her license revoked, or has been ordered to be on probation for a violation constituting a threat to public health and safety.
- Any violation constituting a threat to public health and safety where the Board believes notification is appropriate.

This bill would specify that a licensee required to provide a disclosure shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of the disclosure.

This bill would specify that a licensee on probation is not required to provide a disclosure if any of the following applies:

- The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.
- The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.
- The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.
- The licensee does not have a direct treatment relationship with the patient.

This bill would require the Board, on and after July 1, 2018, to provide the following information for licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's website:

- For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

- For probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final probationary order.
- For a licensee granted a probationary license, the causes by which a probationary license was imposed.
- The length of the probation and end date.
- All practice restrictions placed on the license by the Board.

This bill would have repealed the existing vertical enforcement and prosecution model (VE). The Board requested amendments to keep the VE model for sexual abuse or misconduct cases; mental or physical illness cases; complaints against licensees with a prior disciplinary history, who are currently on probation, or have an accusation pending; and for any other complaints that the Board decides would benefit from the VE model. The bill was amended to state that it is the intent of the Legislature to establish a VE model for the joint investigation of an investigation conducted by the Health Quality Investigation Unit and a deputy attorney general in the Health Quality Enforcement Section. The Board will be working with the author's office and other interested parties on VE language.

This bill would add DPMs to the definition of "attending physician" in Health and Safety Code Section 11362.7, which would allow DPMs to recommend medical cannabis.

The Board is currently prohibited from recovering costs for investigations and prosecutions for disciplinary proceedings. This bill would allow the Board to recover these costs from licensees.

In response to stakeholder feedback, this bill would include LMs in the peer review reporting requirements and provisions in existing law. This bill would also add LMs to the listing of medical corporations.

This bill would have transferred research psychoanalysts to the Board of Psychology. This was brought up in the background paper, as psychoanalysis is a discipline of psychology. However, this provision was removed from the bill due to opposition.

This bill was heard in Assembly Business and Professions Committee on July 11, 2017. In the committee analysis and at the hearing, the committee recommended the following amendments:

- 1) To ensure that psychotherapy record confidentiality is preserved while allowing time for a full adjudication of the *Cross* matter, the Author should amend the bill as follows: Strike language contained in Section 65 regarding the inapplicability of the psychotherapist-patient privilege for investigations or proceedings conducted by the Board.
- 2) To address due process issues, the Author should amend the bill as follows: Amend Section 66 regarding probation disclosures to provide the Board with discretion to impose the requirement on licensees who have actually committed one of the enumerated serious offenses

pursuant to a settlement admission or an ALJ finding; remove both paragraphs (2) and (3) regarding disclosure requirements for licensees with prior disciplinary histories and for additional offenses determined by the Board to warrant disclosure.

3) To allow sufficient time for licensees and the Board to consider settlements prior to requiring expert witness reports, the Author should amend the bill as follows: Amend Section 69 regarding expert witness report exchanges to remove the amended “90 days from the filing of an accusation” timeline.

At the committee hearing, Senator Hill agreed to amendments 1 and 3, but instead of making the probation notification amendments in 2, he wanted to remove Section 66 from the bill entirely. SB 798 remains in the Assembly Business and Professions Committee.

This bill would extend the Board’s sunset date for another four years and would address many of the new issues raised in the Board’s 2016 Sunset Review Report. This bill includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board’s Licensing and Enforcement Programs, and most importantly, to enhance consumer protection.

At the last Board Meeting the Board took a support if amended position and requested amendments to the probation notification language; the Board’s requested language is currently contained in SB 798. The Board also requested amendments to keep the VE model for sexual abuse or misconduct cases; mental or physical illness cases; complaints against licensees with a prior disciplinary history, who are currently on probation, or have an accusation pending; and for any other complaints that the Board decides would benefit from the VE model. There is now intent language in this bill regarding VE and this issue will be addressed after input from stakeholders. Lastly, the Board requested that this bill be amended to include language to transfer the Board’s investigators from the Department of Consumer Affairs, Health Quality Investigation Unit, back to the Board; however, this will likely not happen this year. Many of the Board’s suggested amendments have been made or will be addressed, and Board staff suggests that the Board support the language in SB 798 in its current form, and also support the language if the Assembly Business and Professions Committee recommended amendments are made, or if the probation notification language is removed in its entirety.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: Board of Podiatric Medicine
Consumers Union
Medical Board of California (if amended)
Naturopathic Medicine Committee

OPPOSITION: California Academy of Attorneys for Health Care Professionals;
California Academy of Child & Adolescent Psychiatry; California
Association for Licensed Professional Clinical Counselors; California

Medical Association; California Psychiatric Association; California Psychological Association; California Society of Dermatology and Dermatologic Surgery; Center for Public Interest Law; Depression and Bipolar Support Alliance; Disability Rights California; National Association of Social Workers; and 1 Individual

POSITION:

Recommendation: Support

AMENDED IN ASSEMBLY JULY 6, 2017

AMENDED IN SENATE MAY 26, 2017

AMENDED IN SENATE MAY 17, 2017

AMENDED IN SENATE APRIL 18, 2017

SENATE BILL

No. 798

Introduced by Senator Hill

February 17, 2017

An act to amend Sections 115.6, 125.3, 144, 146, 328, 651, 656, 683, 800, 803.1, 805, 805.01, 805.1, 805.5, 805.6, 810, 2001, ~~2006~~, 2008, 2020, 2054, 2064, 2065, 2066.5, 2082, 2084, 2084.5, 2087, 2096, 2105, 2111, 2112, 2113, 2135, 2135.5, 2143, 2168.4, 2191, 2216.3, 2220.05, 2221, 2225, 2232, 2334, 2415, 2421, 2423, 2435, 2435.2, 2445, 2450, 2454.5, 2460, 2461, 2472, 2475, 2479, 2486, 2488, 2492, 2499, 2525.2, 4170, and 4175 of, to amend and repeal Sections 2529, 2529.1, 2529.5, and 2529.6 of, to add Sections 2026, 2064.5, 2216.5, 2228.1, 2291.5, 2499.7, ~~2566.2, 2950, 2951, 2952, 2953, and 2954~~ to, to add the heading of Article 3.5 (commencing with Section 2950) to Chapter 6.6 of Division 2 of, and 2566.2 to, to repeal Sections 2052.5, 2066, 2067, 2072, 2073, 2085, 2089, 2089.5, 2089.7, 2090, 2091, 2091.1, 2091.2, 2100, 2102, 2103, 2104, 2104.5, 2107, 2115, 2135.7, 2420, and 2422 of, and to repeal the heading of Chapter 5.1 (commencing with Section 2529) of Division 2 of, the Business and Professions Code, to amend Sections 43.7 and 43.8 of the Civil Code, to amend Sections 13401 and 13401.5 of the Corporations Code, to amend Section 1157 of the Evidence Code, to amend ~~Section 11529 of, and to repeal Section 12529.6 of, Sections 11529 and 12529.6 of~~ the Government Code, and to amend Sections 11362.7 and 128335 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 798, as amended, Hill. Healing arts: boards.

(1) Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensure and regulation of physicians and surgeons. Existing law requires the Governor to appoint members to the board, as provided. Existing law authorizes the board to employ an executive director, investigators, legal counsel, medical consultants, and other assistance as specified. Existing law requires the Attorney General to act as legal counsel for the board, as specified. Existing law provides that those provisions will be repealed on January 1, 2018.

This bill would instead repeal those provisions on January 1, 2022.

Existing law requires all moneys paid to and received by the Medical Board of California to be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California, which, except for fine and penalty money, is a continuously appropriated fund.

This bill would make the moneys in the fund available upon appropriation by the Legislature.

~~(2) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified. Existing law requires a registrant to pay into the Contingent Fund of the Medical Board of California a fee fixed by that board, as specified. Existing law, the Psychology Law, makes a violation of its provisions a crime.~~

~~This bill, on January 1, 2019, would transfer the administration and enforcement duties of those provisions from the Medical Board of California to the Board of Psychology. The bill, on January 1, 2019, would require that any moneys within the Contingent Fund of the Medical Board of California collected pursuant to those provisions be deposited in the Psychology Fund, and would require a registrant to pay into the Psychology Fund a fee fixed by the Board of Psychology. The bill, on January 1, 2019, would authorize the Board of Psychology to employ, subject to civil service regulations, whatever additional clerical assistance is necessary for the administration of these provisions. The bill, on January 1, 2019, would require the agreements entered into, and the orders and regulations issued by, the Medical Board of California~~

~~to continue in effect as if the agreements were entered into with, and the orders and regulations were issued by, the Board of Psychology. By placing these provisions in the Psychology Law, the bill would expand the definition of a crime, thereby imposing a state-mandated local program.~~

~~(3)~~

(2) Existing law establishes a peer review process for certain healing arts licensees and requires peer review bodies to review licensee conduct under specified circumstances. Existing law makes the willful failure of a peer review body to make specified reports a crime. Existing law provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, certain health related professional societies or its members for acts performed within the scope of the functions of peer review, as provided.

This bill would apply these provisions to licensed midwives. Because the willful failure of such a peer review body to make specified reports would be punishable as a crime, the bill would impose a state-mandated local program.

Existing law prohibits the proceedings and records of organized committees of healing arts professions or of a peer review body from being subject to discovery, except as specified.

This bill would apply these provisions to the proceedings and records of committees or peer review bodies of licensed midwives, except as specified.

The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act authorizes specified healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating to ownership of shares.

This bill would add licensed midwives to the lists of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation, a psychological corporation, a nursing corporation, a marriage and family therapist corporation, a licensed clinical social worker corporation, a physician assistants corporation, a chiropractic corporation, an acupuncture corporation, a naturopathic doctor corporation, a professional clinical counselor corporation, a physical therapy corporation, and a registered dental hygienist in alternative practice corporation. The bill would also

add a licensed midwives corporation to the list of professional corporations, and would authorize licensed physicians and surgeons, licensed psychologists, registered nurses, licensed marriage and family therapists, licensed clinical social workers, licensed physician assistants, licensed chiropractors, licensed acupuncturists, licensed naturopathic doctors, licensed professional clinical counselors, and licensed physical therapists to be shareholders, officers, directors, or professional employees, subject to those limitations relating to ownership of shares.

(4)

(3) Existing law, the Medical Practice Act, creates, within the Department of Consumer Affairs, the Medical Board of California consisting of 15 members. The act requires the board to elect a president from its members, and authorizes the board to appoint panels from its members for the purpose of fulfilling specified obligations. The act prohibits the president of the board from being a member of any panel unless there is a vacancy in the membership of the board.

This bill would discontinue that prohibition on the president being a member of a panel.

Existing law requires the Office of Statewide Health Planning and Development to establish a nonprofit public benefit corporation known as the Health Professions Education Foundation to perform various duties with respect to implementing health professions scholarship and loan programs. Existing law requires the foundation to be governed by a board consisting of 9 members appointed by the Governor, one member appointed by the Speaker of the Assembly, and one member appointed by the Senate Committee on Rules. Existing law requires the Governor to appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. Existing law requires the members of the board to serve without compensation but requires that they be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board.

This bill would add to that governing board of the foundation 2 members appointed by the Medical Board of California. The bill would include these members in the list of members from which the Governor is required to appoint the president of the board. The bill would require the Medical Board of California to reimburse its 2 appointed members for any actual and necessary expenses incurred in connection with their duties as members of the board. The bill would require the Medical Board of California to reimburse its 2 appointed foundation board

members for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.

Existing law, the Medical Practice Act, requires the Medical Board of California to post on the Internet certain information regarding licensed physicians and surgeons.

This bill would require the board to initiate the process of adopting regulations on or before January 1, 2019, to require its licentiates and registrants to provide notice to their clients or patients that the practitioner is licensed or registered in this state by the board, that the practitioner's license can be checked, and that complaints against the practitioner can be made through the board's Internet Web site or by ~~the contracting~~ *contacting* the board.

Existing law makes it unlawful for a healing arts practitioner to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law prohibits a physician and surgeon from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association is one of a specified list of boards and associations, including a board or association with equivalent requirements approved by that physician and surgeon's licensing board. Existing law requires the Medical Board of California to adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition.

This bill would discontinue the Medical Board of California approval of a board or association. The bill would continue to authorize a physician and surgeon to make a statement that he or she is certified or eligible for certification by a board or association with equivalent requirements approved by that ~~physician~~ *physician's* and surgeon's licensing board prior to January 1, 2019.

Existing law requires each applicant for a physician's and surgeon's certificate to show by official transcript or other official evidence that he or she has successfully completed a medical curriculum meeting specified requirements.

This bill would remove these medical curriculum requirements.

Existing law requires an applicant to show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training. Existing law requires the postgraduate training to be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada.

This bill would instead require an applicant to show by evidence satisfactory to the board that he or she has satisfactorily completed at least 36 months of board-approved postgraduate training. The bill would authorize an applicant to obtain postgraduate training in a postgraduate training program approved by the College of Family Physicians of Canada. The bill would make eligible for licensure an applicant who has completed at least 36 months of board-approved postgraduate training, not less than 24 months of which was completed as a resident after receiving a medical degree from a combined dental and medical degree program accredited by the Commission on Dental Accreditation or approved by the board.

Existing law authorizes a graduate of an approved medical school who is enrolled in a postgraduate training program approved by the board to engage in the practice of medicine whenever and wherever required as part of the program under specified conditions.

This bill would add to these conditions a requirement that the medical school graduate obtain a postgraduate training license, as specified.

Existing law requires an applicant who is a graduate of a medical school located outside of the United States or Canada to make an application to the board prior to commencing any postgraduate training in this state. Existing law authorizes the board to deny a postgraduate training authorization letter to an applicant who is guilty of unprofessional conduct or of any cause for revocation or suspension of a license.

This bill would remove the authorization of the board to deny a postgraduate training authorization letter to an applicant for those reasons.

Existing law requires an applicant for a physician's and surgeon's certificate whose professional instruction was acquired in a country other than the United States or Canada to provide evidence satisfactory to the board of satisfactory completion of various requirements, including showing by evidence satisfactory to the board that he or she has satisfactorily completed at least 2 years of postgraduate training.

This bill would recast some of those provisions and make conforming changes to other provisions. The bill would require those applicants to show by evidence satisfactory to the board that he or she has satisfactorily completed at least 36 months of board-approved postgraduate training.

Under existing law, ~~a physician's and surgeon's license expires and becomes~~ *specified licenses, certificates, registrations, and permits issued by or under the Medical Board of California expire and become* invalid at midnight on the last day of February of each even numbered year, if not renewed, as specified.

This bill would repeal this provision.

Existing law authorizes the holder of a special faculty permit to practice medicine, without a physician's and surgeon's certificate, within a medical school and certain affiliated institutions. Under existing law, a special faculty permit expires and becomes invalid at midnight on the last day of the permitholder's birth month during the 2nd year of a 2-year term, if not renewed.

The bill would instead specify that a special faculty permit expires and becomes invalid at midnight on the last day of the month in which the permit was issued during the 2nd year of a 2-year term commencing from the date of issuance, if not renewed.

The Medical Practice Act creates, within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine. Under the act, certificates to practice podiatric medicine expire on a certain date during the 2nd year of a 2-year term if not renewed. The act authorizes a doctor of podiatric medicine who is ankle certified, as specified, to perform certain services and procedures.

This bill would instead create the California Board of Podiatric Medicine in the Department of Consumer Affairs, and would make conforming and related changes. The bill would prohibit construing the amendments made by the bill relating to podiatrists to change any rights or privileges held by podiatrists prior to enactment of the bill. The bill would discontinue the ankle certification requirement for a doctor of podiatric medicine to perform those services and procedures.

Under the act, certificates to practice podiatric medicine and registrations of spectacle lens dispensers and contact lens dispensers, among others, expire on a certain date during the 2nd year of a 2-year term if not renewed.

This bill would discontinue the requirement for the expiration of the registrations of spectacle lens dispensers and contact lens dispensers.

Existing law requires the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of a peer review body, as defined, and the chief executive officer or administrator of a licensed health care facility or clinic to file reports with the applicable state licensing agency of specified health care practitioners upon the occurrence of specified events.

~~This bill would additionally require state agencies and hospitals to report to the Medical Board of California any peer review incidents subject to those provisions that are found during an inspection of a health care facility or clinic. The bill would impose a \$100,000 fine for a willful failure to file a specified report and a \$50,000 fine for all other failures to file the report.~~

Existing law requires an accredited outpatient setting to report an adverse event, as defined, to the Medical Board of California no later than 5 days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected.

This bill would redefine adverse event for those purposes and would require the outpatient setting to inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The bill would require an accredited outpatient setting to annually file a report containing information related to patient service with the Office of Statewide Health Planning and Development, as specified.

Existing law requires the board to promptly revoke the license of any person who has been required to register as a sex offender. Existing law authorizes certain individuals whose license was revoked under this provision to petition a specified superior court to hold a hearing within one year of the date of the petition, in order for the court to determine whether the individual no longer poses a possible risk to patients. Existing law authorizes the Attorney General and the board to present written and oral argument to the court on the merits of the petition.

This bill would instead require the board to make the revocation automatically, regardless of whether the related conviction has been appealed. The bill would require the board to notify the licensee of the license revocation and of his or her right to elect to have a hearing. The bill would authorize the holder of the physician's and surgeon's certificate to request a hearing, as specified, within 30 days of the

revocation. The bill would require the revocation to cease automatically if the conviction is overturned on appeal. The bill would require the Attorney General and the board to present written and oral argument to the court on the merits of a petition to determine whether an individual who was required to register as a sex offender no longer poses a possible risk to patients.

Existing law makes certain privileged communication provisions not applicable to investigations or proceedings related to violations of the Medical Practice Act.

This bill would specify that provisions pertaining to the psychotherapist-patient privilege are also not applicable to those investigations or proceedings.

Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending a license or imposing license restrictions, as specified. Existing law requires the order to be dissolved if an accusation is not filed and served, as specified, within 30 days of the date on which the parties to the hearing on the order have submitted the matter.

This bill would also require the order to be dissolved if a petition to revoke probation is not filed and served, as specified, within 30 days of the date on which the parties to the hearing on the order have submitted the matter.

Existing law prohibits a party's use of expert testimony in matters brought by the Medical Board of California unless specified information, including a brief narrative statement of the general substance of the testimony that the expert is expected to give, is exchanged in written form with the counsel for the other party. Existing law requires the exchange of information to be completed at least 30 days prior to the commencement date of the hearing.

This bill would instead require the exchange of information to be completed either within 90 days from the filing of an accusation or petition to revoke probation or 30 calendar days prior to the originally scheduled commencement date of the hearing, whichever occurs first, or as determined by an administrative law judge, as specified. The bill would replace the requirement that a brief narrative statement be exchanged with the requirement that a complete expert witness report, as specified, be exchanged.

Under existing law, if a healing arts licensee may be unable to practice his or her profession safely due to mental or physical illness, his or her licensing agency may order the licensee to be examined by specified

professionals. Existing law specifies that a licentiate's failure to comply with this order constitutes grounds for the suspension or revocation of the licentiate's certificate or license.

This bill would ~~require that~~ *authorize* a physician's and surgeon's failure to comply with an order related to these examination requirements *to result in the issuance of notification from the board to cease the practice of medicine immediately until the ordered examinations have been completed and would provide that completed.* *The bill would require the continued failure to comply would to be* grounds for suspension or revocation of his or her certificate.

Existing law establishes the Health Quality Enforcement Section within the Department of Justice to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California. Existing law requires each complaint that is referred to a district office of one of these boards for investigation to be jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section of the Department of Justice responsible for prosecuting the case if the investigation results in the filing of an accusation.

This bill would remove this ~~requirement, and make conforming changes:~~ *requirement and declare the intent of the Legislature to establish a vertical enforcement and prosecution model, as provided.*

Existing law establishes the State Board of Chiropractic Examiners, the Medical Board of California, the California Board of Podiatric Medicine within the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee, and the Acupuncture Board for the licensure and regulation of chiropractors, physicians and surgeons, podiatrists, osteopathic physicians and surgeons, naturopathic doctors, and acupuncturists, respectively. Existing law authorizes each of those regulatory entities to discipline its licensee by placing that licensee on probation, as specified. Existing law also requires 3 of those regulatory entities, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine, to disclose to an inquiring member of the public and to post on their Internet Web sites specified information concerning licensees including revocations, suspensions, probations, and limitations on practice.

This bill, on and after July 1, 2018, would require each of those regulatory entities to require a specified licensee on probation pursuant to a probationary order made on or after July 1, 2018, to provide a patient, or the patient's guardian or health care surrogate, with a separate disclosure containing specified information relating to the licensee's probationary status, with certain exceptions, and would require the licensee to obtain a signed copy of that disclosure from the patient, or the patient's guardian or health care surrogate. The bill would further require each of those regulatory entities, on and after July 1, 2018, to provide certain information regarding licensees on probation and licensees practicing under probationary licenses to an inquiring member of the public, on any of the regulatory entity's documents informing the public of individual probation orders and probationary licenses, and in plain view on the licensee's profile page on the regulatory entity's online license information *Internet Web* site.

Existing law, in any order issued in resolution of a disciplinary proceeding before any board within the Department of Consumer Affairs or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding unless the entity is the Medical Board of California, authorizes the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, as specified. Existing law requires the Medical Board of California to ensure that any loss of revenue or increases in costs incurred pursuant to its inability to request and obtain investigation and prosecution costs for a disciplinary proceeding is offset by initial license and renewal fees.

This bill would authorize the Medical Board of California to request and obtain from a physician and surgeon the investigation and prosecution costs for a disciplinary proceeding and would make related and conforming changes.

Existing law, the Osteopathic Act, establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons and requires that the powers and duties of the board in that regard be subject to review by the appropriate committees of the Legislature. Existing law requires that review to be performed as if those provisions were scheduled to be repealed as of January 1, 2018.

This bill would instead require that review to be performed as if those provisions were scheduled to be repealed as of January 1, 2022.

Existing law requires the Osteopathic Medical Board of California to require each licensed osteopathic physician and surgeon to demonstrate satisfaction of continuing education requirements as a condition for the renewal of a license at intervals of not less than one year nor more than 3 years. Existing law requires the board to require each licensed osteopathic physician and surgeon to complete a minimum of 150 hours of American Osteopathic Association continuing education hours during each 3-year cycle, of which 60 hours must be completed in American Osteopathic Association Category 1 continuing education hours as a condition for renewal of an active license.

This bill would instead require the board to require satisfaction of the continuing education requirements not less than one year nor more than 2 years. The bill would require each licensed osteopathic physician and surgeon to complete a minimum of 100 hours of American Osteopathic Association continuing education hours during each 2-year cycle, of which 40 hours must be completed in American Osteopathic Association Category 1 continuing education hours and the remaining 60 hours shall be either American Osteopathic Association or American Medical Association accredited.

Existing law authorizes a list of specified boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other documentation needed to complete an applicant or licensee investigation.

This bill would add the California Board of Podiatric Medicine and the Osteopathic Medical Board of California to that list of specified boards.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 115.6 of the Business and Professions
- 2 Code is amended to read:
- 3 115.6. (a) A board within the department shall, after
- 4 appropriate investigation, issue the following eligible temporary

1 licenses to an applicant if he or she meets the requirements set
2 forth in subdivision (c):

3 (1) Registered nurse license by the Board of Registered Nursing.

4 (2) Vocational nurse license issued by the Board of Vocational
5 Nursing and Psychiatric Technicians of the State of California.

6 (3) Psychiatric technician license issued by the Board of
7 Vocational Nursing and Psychiatric Technicians of the State of
8 California.

9 (4) Speech-language pathologist license issued by the
10 Speech-Language Pathology and Audiology and Hearing Aid
11 Dispensers Board.

12 (5) Audiologist license issued by the Speech-Language
13 Pathology and Audiology and Hearing Aid Dispensers Board.

14 (6) Veterinarian license issued by the Veterinary Medical Board.

15 (7) All licenses issued by the Board for Professional Engineers,
16 Land Surveyors, and Geologists.

17 (8) All licenses issued by the Medical Board of California.

18 (9) All licenses issued by the California Board of Podiatric
19 Medicine.

20 (b) The board may conduct an investigation of an applicant for
21 purposes of denying or revoking a temporary license issued
22 pursuant to this section. This investigation may include a criminal
23 background check.

24 (c) An applicant seeking a temporary license pursuant to this
25 section shall meet the following requirements:

26 (1) The applicant shall supply evidence satisfactory to the board
27 that the applicant is married to, or in a domestic partnership or
28 other legal union with, an active duty member of the Armed Forces
29 of the United States who is assigned to a duty station in this state
30 under official active duty military orders.

31 (2) The applicant shall hold a current, active, and unrestricted
32 license that confers upon him or her the authority to practice, in
33 another state, district, or territory of the United States, the
34 profession or vocation for which he or she seeks a temporary
35 license from the board.

36 (3) The applicant shall submit an application to the board that
37 shall include a signed affidavit attesting to the fact that he or she
38 meets all of the requirements for the temporary license and that
39 the information submitted in the application is accurate, to the best
40 of his or her knowledge. The application shall also include written

1 verification from the applicant's original licensing jurisdiction
2 stating that the applicant's license is in good standing in that
3 jurisdiction.

4 (4) The applicant shall not have committed an act in any
5 jurisdiction that would have constituted grounds for denial,
6 suspension, or revocation of the license under this code at the time
7 the act was committed. A violation of this paragraph may be
8 grounds for the denial or revocation of a temporary license issued
9 by the board.

10 (5) The applicant shall not have been disciplined by a licensing
11 entity in another jurisdiction and shall not be the subject of an
12 unresolved complaint, review procedure, or disciplinary proceeding
13 conducted by a licensing entity in another jurisdiction.

14 (6) The applicant shall, upon request by a board, furnish a full
15 set of fingerprints for purposes of conducting a criminal
16 background check.

17 (d) A board may adopt regulations necessary to administer this
18 section.

19 (e) A temporary license issued pursuant to this section may be
20 immediately terminated upon a finding that the temporary
21 licenseholder failed to meet any of the requirements described in
22 subdivision (c) or provided substantively inaccurate information
23 that would affect his or her eligibility for temporary licensure.
24 Upon termination of the temporary license, the board shall issue
25 a notice of termination that shall require the temporary
26 licenseholder to immediately cease the practice of the licensed
27 profession upon receipt.

28 (f) An applicant seeking a temporary license as a civil engineer,
29 geotechnical engineer, structural engineer, land surveyor,
30 professional geologist, professional geophysicist, certified
31 engineering geologist, or certified hydrogeologist pursuant to this
32 section shall successfully pass the appropriate California-specific
33 examination or examinations required for licensure in those
34 respective professions by the Board for Professional Engineers,
35 Land Surveyors, and Geologists.

36 (g) A temporary license issued pursuant to this section shall
37 expire 12 months after issuance, upon issuance of an expedited
38 license pursuant to Section 115.5, or upon denial of the application
39 for expedited licensure by the board, whichever occurs first.

1 SEC. 2. Section 125.3 of the Business and Professions Code
2 is amended to read:

3 125.3. (a) Except as otherwise provided by law, in any order
4 issued in resolution of a disciplinary proceeding before any board
5 within the department or before the Osteopathic Medical Board,
6 upon request of the entity bringing the proceeding, the
7 administrative law judge may direct a licentiate found to have
8 committed a violation or violations of the licensing act to pay a
9 sum not to exceed the reasonable costs of the investigation and
10 enforcement of the case.

11 (b) In the case of a disciplined licentiate that is a corporation or
12 a partnership, the order may be made against the licensed corporate
13 entity or licensed partnership.

14 (c) A certified copy of the actual costs, or a good faith estimate
15 of costs where actual costs are not available, signed by the entity
16 bringing the proceeding or its designated representative shall be
17 prima facie evidence of reasonable costs of investigation and
18 prosecution of the case. The costs shall include the amount of
19 investigative and enforcement costs up to the date of the hearing,
20 including, but not limited to, charges imposed by the Attorney
21 General.

22 (d) The administrative law judge shall make a proposed finding
23 of the amount of reasonable costs of investigation and prosecution
24 of the case when requested pursuant to subdivision (a). The finding
25 of the administrative law judge with regard to costs shall not be
26 reviewable by the board to increase the cost award. The board may
27 reduce or eliminate the cost award, or remand to the administrative
28 law judge if the proposed decision fails to make a finding on costs
29 requested pursuant to subdivision (a).

30 (e) If an order for recovery of costs is made and timely payment
31 is not made as directed in the board's decision, the board may
32 enforce the order for repayment in any appropriate court. This
33 right of enforcement shall be in addition to any other rights the
34 board may have as to any licentiate to pay costs.

35 (f) In any action for recovery of costs, proof of the board's
36 decision shall be conclusive proof of the validity of the order of
37 payment and the terms for payment.

38 (g) (1) Except as provided in paragraph (2), the board shall not
39 renew or reinstate the license of any licentiate who has failed to
40 pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

SEC. 3. Section 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

(1) California Board of Accountancy.

(2) State Athletic Commission.

(3) Board of Behavioral Sciences.

(4) Court Reporters Board of California.

(5) State Board of Guide Dogs for the Blind.

(6) California State Board of Pharmacy.

(7) Board of Registered Nursing.

(8) Veterinary Medical Board.

(9) Board of Vocational Nursing and Psychiatric Technicians.

(10) Respiratory Care Board of California.

(11) Physical Therapy Board of California.

(12) Physician Assistant Committee of the Medical Board of California.

1 (13) Speech-Language Pathology and Audiology and Hearing
2 Aid Dispensers Board.

3 (14) Medical Board of California.

4 (15) State Board of Optometry.

5 (16) Acupuncture Board.

6 (17) Cemetery and Funeral Bureau.

7 (18) Bureau of Security and Investigative Services.

8 (19) Division of Investigation.

9 (20) Board of Psychology.

10 (21) California Board of Occupational Therapy.

11 (22) Structural Pest Control Board.

12 (23) Contractors' State License Board.

13 (24) Naturopathic Medicine Committee.

14 (25) Professional Fiduciaries Bureau.

15 (26) Board for Professional Engineers, Land Surveyors, and
16 Geologists.

17 (27) Bureau of Medical Cannabis Regulation.

18 (28) California Board of Podiatric Medicine.

19 (29) Osteopathic Medical Board of California.

20 (c) For purposes of paragraph (26) of subdivision (b), the term
21 "applicant" shall be limited to an initial applicant who has never
22 been registered or licensed by the board or to an applicant for a
23 new licensure or registration category.

24 SEC. 4. Section 146 of the Business and Professions Code is
25 amended to read:

26 146. (a) Notwithstanding any other provision of law, a
27 violation of any code section listed in subdivision (c) is an
28 infraction subject to the procedures described in Sections 19.6 and
29 19.7 of the Penal Code when either of the following applies:

30 (1) A complaint or a written notice to appear in court pursuant
31 to Chapter 5C (commencing with Section 853.5) of Title 3 of Part
32 2 of the Penal Code is filed in court charging the offense as an
33 infraction unless the defendant, at the time he or she is arraigned,
34 after being advised of his or her rights, elects to have the case
35 proceed as a misdemeanor.

36 (2) The court, with the consent of the defendant and the
37 prosecution, determines that the offense is an infraction in which
38 event the case shall proceed as if the defendant has been arraigned
39 on an infraction complaint.

(b) Subdivision (a) does not apply to a violation of the code sections listed in subdivision (c) if the defendant has had his or her license, registration, or certificate previously revoked or suspended.

(c) The following sections require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions regulated by this code:

- (1) Section 2474.
- (2) Sections 2052 and 2054.
- (3) Section 2630.
- (4) Section 2903.
- (5) Section 3575.
- (6) Section 3660.
- (7) Sections 3760 and 3761.
- (8) Section 4080.
- (9) Section 4825.
- (10) Section 4935.
- (11) Section 4980.
- (12) Section 4989.50.
- (13) Section 4996.
- (14) Section 4999.30.
- (15) Section 5536.
- (16) Section 6704.
- (17) Section 6980.10.
- (18) Section 7317.
- (19) Section 7502 or 7592.
- (20) Section 7520.
- (21) Section 7617 or 7641.
- (22) Subdivision (a) of Section 7872.
- (23) Section 8016.
- (24) Section 8505.
- (25) Section 8725.
- (26) Section 9681.
- (27) Section 9840.
- (28) Subdivision (c) of Section 9891.24.
- (29) Section 19049.

(d) Notwithstanding any other law, a violation of any of the sections listed in subdivision (c), which is an infraction, is punishable by a fine of not less than two hundred fifty dollars (\$250) and not more than one thousand dollars (\$1,000). No portion

1 of the minimum fine may be suspended by the court unless as a
2 condition of that suspension the defendant is required to submit
3 proof of a current valid license, registration, or certificate for the
4 profession or vocation that was the basis for his or her conviction.

5 SEC. 5. Section 328 of the Business and Professions Code is
6 amended to read:

7 328. (a) In order to implement the Consumer Protection
8 Enforcement Initiative of 2010, the director, through the Division
9 of Investigation, shall implement “Complaint Prioritization
10 Guidelines” for boards to utilize in prioritizing their respective
11 complaint and investigative workloads. The guidelines shall be
12 used to determine the referral of complaints to the division and
13 those that are retained by the health care boards for investigation.

14 (b) Neither the Medical Board of California nor the California
15 Board of Podiatric Medicine shall be required to utilize the
16 guidelines implemented pursuant to subdivision (a).

17 SEC. 6. Section 651 of the Business and Professions Code is
18 amended to read:

19 651. (a) It is unlawful for any person licensed under this
20 division or under any initiative act referred to in this division to
21 disseminate or cause to be disseminated any form of public
22 communication containing a false, fraudulent, misleading, or
23 deceptive statement, claim, or image for the purpose of or likely
24 to induce, directly or indirectly, the rendering of professional
25 services or furnishing of products in connection with the
26 professional practice or business for which he or she is licensed.
27 A “public communication” as used in this section includes, but is
28 not limited to, communication by means of mail, television, radio,
29 motion picture, newspaper, book, list or directory of healing arts
30 practitioners, Internet, or other electronic communication.

31 (b) A false, fraudulent, misleading, or deceptive statement,
32 claim, or image includes a statement or claim that does any of the
33 following:

34 (1) Contains a misrepresentation of fact.

35 (2) Is likely to mislead or deceive because of a failure to disclose
36 material facts.

37 (3) (A) Is intended or is likely to create false or unjustified
38 expectations of favorable results, including the use of any
39 photograph or other image that does not accurately depict the
40 results of the procedure being advertised or that has been altered

1 in any manner from the image of the actual subject depicted in the
2 photograph or image.

3 (B) Use of any photograph or other image of a model without
4 clearly stating in a prominent location in easily readable type the
5 fact that the photograph or image is of a model is a violation of
6 subdivision (a). For purposes of this paragraph, a model is anyone
7 other than an actual patient, who has undergone the procedure
8 being advertised, of the licensee who is advertising for his or her
9 services.

10 (C) Use of any photograph or other image of an actual patient
11 that depicts or purports to depict the results of any procedure, or
12 presents “before” and “after” views of a patient, without specifying
13 in a prominent location in easily readable type size what procedures
14 were performed on that patient is a violation of subdivision (a).
15 Any “before” and “after” views (i) shall be comparable in
16 presentation so that the results are not distorted by favorable poses,
17 lighting, or other features of presentation, and (ii) shall contain a
18 statement that the same “before” and “after” results may not occur
19 for all patients.

20 (4) Relates to fees, other than a standard consultation fee or a
21 range of fees for specific types of services, without fully and
22 specifically disclosing all variables and other material factors.

23 (5) Contains other representations or implications that in
24 reasonable probability will cause an ordinarily prudent person to
25 misunderstand or be deceived.

26 (6) Makes a claim either of professional superiority or of
27 performing services in a superior manner, unless that claim is
28 relevant to the service being performed and can be substantiated
29 with objective scientific evidence.

30 (7) Makes a scientific claim that cannot be substantiated by
31 reliable, peer reviewed, published scientific studies.

32 (8) Includes any statement, endorsement, or testimonial that is
33 likely to mislead or deceive because of a failure to disclose material
34 facts.

35 (c) Any price advertisement shall be exact, without the use of
36 phrases, including, but not limited to, “as low as,” “and up,”
37 “lowest prices,” or words or phrases of similar import. Any
38 advertisement that refers to services, or costs for services, and that
39 uses words of comparison shall be based on verifiable data
40 substantiating the comparison. Any person so advertising shall be

1 prepared to provide information sufficient to establish the accuracy
2 of that comparison. Price advertising shall not be fraudulent,
3 deceitful, or misleading, including statements or advertisements
4 of bait, discount, premiums, gifts, or any statements of a similar
5 nature. In connection with price advertising, the price for each
6 product or service shall be clearly identifiable. The price advertised
7 for products shall include charges for any related professional
8 services, including dispensing and fitting services, unless the
9 advertisement specifically and clearly indicates otherwise.

10 (d) Any person so licensed shall not compensate or give anything
11 of value to a representative of the press, radio, television, or other
12 communication medium in anticipation of, or in return for,
13 professional publicity unless the fact of compensation is made
14 known in that publicity.

15 (e) Any person so licensed may not use any professional card,
16 professional announcement card, office sign, letterhead, telephone
17 directory listing, medical list, medical directory listing, or a similar
18 professional notice or device if it includes a statement or claim
19 that is false, fraudulent, misleading, or deceptive within the
20 meaning of subdivision (b).

21 (f) Any person so licensed who violates this section is guilty of
22 a misdemeanor. A bona fide mistake of fact shall be a defense to
23 this subdivision, but only to this subdivision.

24 (g) Any violation of this section by a person so licensed shall
25 constitute good cause for revocation or suspension of his or her
26 license or other disciplinary action.

27 (h) Advertising by any person so licensed may include the
28 following:

29 (1) A statement of the name of the practitioner.

30 (2) A statement of addresses and telephone numbers of the
31 offices maintained by the practitioner.

32 (3) A statement of office hours regularly maintained by the
33 practitioner.

34 (4) A statement of languages, other than English, fluently spoken
35 by the practitioner or a person in the practitioner's office.

36 (5) (A) A statement that the practitioner is certified by a private
37 or public board or agency or a statement that the practitioner limits
38 his or her practice to specific fields.

39 (B) A statement of certification by a practitioner licensed under
40 Chapter 7 (commencing with Section 3000) shall only include a

1 statement that he or she is certified or eligible for certification by
2 a private or public board or parent association recognized by that
3 practitioner's licensing board.

4 (C) A physician and surgeon licensed under Chapter 5
5 (commencing with Section 2000) by the Medical Board of
6 California may include a statement that he or she limits his or her
7 practice to specific fields, but shall not include a statement that he
8 or she is certified or eligible for certification by a private or public
9 board or parent association, including, but not limited to, a
10 multidisciplinary board or association, unless that board or
11 association is (i) an American Board of Medical Specialties
12 member board, (ii) a board or association with equivalent
13 requirements approved by that physician's and surgeon's licensing
14 board prior to January 1, 2019, or (iii) a board or association with
15 an Accreditation Council for Graduate Medical Education approved
16 postgraduate training program that provides complete training in
17 that specialty or subspecialty. A physician and surgeon licensed
18 under Chapter 5 (commencing with Section 2000) by the Medical
19 Board of California who is certified by an organization other than
20 a board or association referred to in clause (i), (ii), or (iii) shall not
21 use the term "board certified" in reference to that certification,
22 unless the physician and surgeon is also licensed under Chapter 4
23 (commencing with Section 1600) and the use of the term "board
24 certified" in reference to that certification is in accordance with
25 subparagraph (A). A physician and surgeon licensed under Chapter
26 5 (commencing with Section 2000) by the Medical Board of
27 California who is certified by a board or association referred to in
28 clause (i), (ii), or (iii) shall not use the term "board certified" unless
29 the full name of the certifying board is also used and given
30 comparable prominence with the term "board certified" in the
31 statement.

32 For purposes of this subparagraph, a "multidisciplinary board
33 or association" means an educational certifying body that has a
34 psychometrically valid testing process, as determined by the
35 Medical Board of California, for certifying medical doctors and
36 other health care professionals that is based on the applicant's
37 education, training, and experience. A multidisciplinary board or
38 association approved by the Medical Board of California prior to
39 January 1, 2019, shall retain that approval.

1 For purposes of the term “board certified,” as used in this
2 subparagraph, the terms “board” and “association” mean an
3 organization that is an American Board of Medical Specialties
4 member board, an organization with equivalent requirements
5 approved by a physician’s and surgeon’s licensing board prior to
6 January 1, 2019, or an organization with an Accreditation Council
7 for Graduate Medical Education approved postgraduate training
8 program that provides complete training in a specialty or
9 subspecialty.

10 (D) A doctor of podiatric medicine licensed under Article 22
11 (commencing with Section 2460) of Chapter 5 by the California
12 Board of Podiatric Medicine may include a statement that he or
13 she is certified or eligible or qualified for certification by a private
14 or public board or parent association, including, but not limited
15 to, a multidisciplinary board or association, if that board or
16 association meets one of the following requirements: (i) is approved
17 by the Council on Podiatric Medical Education, (ii) is a board or
18 association with equivalent requirements approved by the
19 California Board of Podiatric Medicine, or (iii) is a board or
20 association with the Council on Podiatric Medical Education
21 approved postgraduate training programs that provide training in
22 podiatric medicine and podiatric surgery. A doctor of podiatric
23 medicine licensed under Article 22 (commencing with Section
24 2460) of Chapter 5 by the California Board of Podiatric Medicine
25 who is certified by a board or association referred to in clause (i),
26 (ii), or (iii) shall not use the term “board certified” unless the full
27 name of the certifying board is also used and given comparable
28 prominence with the term “board certified” in the statement. A
29 doctor of podiatric medicine licensed under Article 22
30 (commencing with Section 2460) of Chapter 5 by the California
31 Board of Podiatric Medicine who is certified by an organization
32 other than a board or association referred to in clause (i), (ii), or
33 (iii) shall not use the term “board certified” in reference to that
34 certification.

35 For purposes of this subparagraph, a “multidisciplinary board
36 or association” means an educational certifying body that has a
37 psychometrically valid testing process, as determined by the
38 California Board of Podiatric Medicine, for certifying doctors of
39 podiatric medicine that is based on the applicant’s education,
40 training, and experience. For purposes of the term “board certified,”

1 as used in this subparagraph, the terms “board” and “association”
2 mean an organization that is a Council on Podiatric Medical
3 Education approved board, an organization with equivalent
4 requirements approved by the California Board of Podiatric
5 Medicine, or an organization with a Council on Podiatric Medical
6 Education approved postgraduate training program that provides
7 training in podiatric medicine and podiatric surgery.

8 The California Board of Podiatric Medicine shall adopt
9 regulations to establish and collect a reasonable fee from each
10 board or association applying for recognition pursuant to this
11 subparagraph, to be deposited in the State Treasury in the Podiatry
12 Fund, pursuant to Section 2499. The fee shall not exceed the cost
13 of administering this subparagraph.

14 (6) A statement that the practitioner provides services under a
15 specified private or public insurance plan or health care plan.

16 (7) A statement of names of schools and postgraduate clinical
17 training programs from which the practitioner has graduated,
18 together with the degrees received.

19 (8) A statement of publications authored by the practitioner.

20 (9) A statement of teaching positions currently or formerly held
21 by the practitioner, together with pertinent dates.

22 (10) A statement of his or her affiliations with hospitals or
23 clinics.

24 (11) A statement of the charges or fees for services or
25 commodities offered by the practitioner.

26 (12) A statement that the practitioner regularly accepts
27 installment payments of fees.

28 (13) Otherwise lawful images of a practitioner, his or her
29 physical facilities, or of a commodity to be advertised.

30 (14) A statement of the manufacturer, designer, style, make,
31 trade name, brand name, color, size, or type of commodities
32 advertised.

33 (15) An advertisement of a registered dispensing optician may
34 include statements in addition to those specified in paragraphs (1)
35 to (14), inclusive, provided that any statement shall not violate
36 subdivision (a), (b), (c), or (e) or any other section of this code.

37 (16) A statement, or statements, providing public health
38 information encouraging preventive or corrective care.

39 (17) Any other item of factual information that is not false,
40 fraudulent, misleading, or likely to deceive.

1 (i) Each of the healing arts boards and examining committees
2 within Division 2 shall adopt appropriate regulations to enforce
3 this section in accordance with Chapter 3.5 (commencing with
4 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
5 Code.

6 Each of the healing arts boards and committees and examining
7 committees within Division 2 shall, by regulation, define those
8 efficacious services to be advertised by businesses or professions
9 under their jurisdiction for the purpose of determining whether
10 advertisements are false or misleading. Until a definition for that
11 service has been issued, no advertisement for that service shall be
12 disseminated. However, if a definition of a service has not been
13 issued by a board or committee within 120 days of receipt of a
14 request from a licensee, all those holding the license may advertise
15 the service. Those boards and committees shall adopt or modify
16 regulations defining what services may be advertised, the manner
17 in which defined services may be advertised, and restricting
18 advertising that would promote the inappropriate or excessive use
19 of health services or commodities. A board or committee shall not,
20 by regulation, unreasonably prevent truthful, nondeceptive price
21 or otherwise lawful forms of advertising of services or
22 commodities, by either outright prohibition or imposition of
23 onerous disclosure requirements. However, any member of a board
24 or committee acting in good faith in the adoption or enforcement
25 of any regulation shall be deemed to be acting as an agent of the
26 state.

27 (j) The Attorney General shall commence legal proceedings in
28 the appropriate forum to enjoin advertisements disseminated or
29 about to be disseminated in violation of this section and seek other
30 appropriate relief to enforce this section. Notwithstanding any
31 other provision of law, the costs of enforcing this section to the
32 respective licensing boards or committees may be awarded against
33 any licensee found to be in violation of any provision of this
34 section. This shall not diminish the power of district attorneys,
35 county counsels, or city attorneys pursuant to existing law to seek
36 appropriate relief.

37 (k) A physician and surgeon licensed pursuant to Chapter 5
38 (commencing with Section 2000) by the Medical Board of
39 California or a doctor of podiatric medicine licensed pursuant to
40 Article 22 (commencing with Section 2460) of Chapter 5 by the

1 California Board of Podiatric Medicine who knowingly and
2 intentionally violates this section may be cited and assessed an
3 administrative fine not to exceed ten thousand dollars (\$10,000)
4 per event. Section 125.9 shall govern the issuance of this citation
5 and fine except that the fine limitations prescribed in paragraph
6 (3) of subdivision (b) of Section 125.9 shall not apply to a fine
7 under this subdivision.

8 SEC. 7. Section 656 of the Business and Professions Code is
9 amended to read:

10 656. Whenever any person has engaged, or is about to engage,
11 in any acts or practices that constitute, or will constitute, a violation
12 of this article, the superior court in and for the county wherein the
13 acts or practices take place, or are about to take place, may issue
14 an injunction, or other appropriate order, restraining the conduct
15 on application of the State Board of Optometry, the Medical Board
16 of California, the California Board of Podiatric Medicine, the
17 Osteopathic Medical Board of California, the Attorney General,
18 or the district attorney of the county.

19 The proceedings under this section shall be governed by Chapter
20 3 (commencing with Section 525) of Title 7 of Part 2 of the Code
21 of Civil Procedure.

22 The remedy provided for in this section shall be in addition to,
23 and not a limitation upon, the authority provided by any other
24 provision of this code.

25 SEC. 8. Section 683 of the Business and Professions Code is
26 amended to read:

27 683. (a) A board shall report, within 10 working days, to the
28 State Department of Health Care Services the name and license
29 number of a person whose license has been revoked, suspended,
30 surrendered, made inactive by the licensee, or placed in another
31 category that prohibits the licensee from practicing his or her
32 profession. The purpose of the reporting requirement is to prevent
33 reimbursement by the state for Medi-Cal and Denti-Cal services
34 provided after the cancellation of a provider's professional license.

35 (b) "Board," as used in this section, means the Dental Board of
36 California, the Medical Board of California, the Board of
37 Psychology, the State Board of Optometry, the California State
38 Board of Pharmacy, the Osteopathic Medical Board of California,
39 the State Board of Chiropractic Examiners, the Board of Behavioral

1 Sciences, the California Board of Podiatric Medicine, and the
2 California Board of Occupational Therapy.

3 (c) This section shall become operative on January 1, 2015.

4 SEC. 9. Section 800 of the Business and Professions Code is
5 amended to read:

6 800. (a) The Medical Board of California, the California Board
7 of Podiatric Medicine, the Board of Psychology, the Dental Board
8 of California, the Dental Hygiene Committee of California, the
9 Osteopathic Medical Board of California, the State Board of
10 Chiropractic Examiners, the Board of Registered Nursing, the
11 Board of Vocational Nursing and Psychiatric Technicians of the
12 State of California, the State Board of Optometry, the Veterinary
13 Medical Board, the Board of Behavioral Sciences, the Physical
14 Therapy Board of California, the California State Board of
15 Pharmacy, the Speech-Language Pathology and Audiology and
16 Hearing Aid Dispensers Board, the California Board of
17 Occupational Therapy, the Acupuncture Board, and the Physician
18 Assistant Board shall each separately create and maintain a central
19 file of the names of all persons who hold a license, certificate, or
20 similar authority from that board. Each central file shall be created
21 and maintained to provide an individual historical record for each
22 licensee with respect to the following information:

23 (1) Any conviction of a crime in this or any other state that
24 constitutes unprofessional conduct pursuant to the reporting
25 requirements of Section 803.

26 (2) Any judgment or settlement requiring the licensee or his or
27 her insurer to pay any amount of damages in excess of three
28 thousand dollars (\$3,000) for any claim that injury or death was
29 proximately caused by the licensee's negligence, error or omission
30 in practice, or by rendering unauthorized professional services,
31 pursuant to the reporting requirements of Section 801 or 802.

32 (3) Any public complaints for which provision is made pursuant
33 to subdivision (b).

34 (4) Disciplinary information reported pursuant to Section 805,
35 including any additional exculpatory or explanatory statements
36 submitted by the licensee pursuant to subdivision (f) of Section
37 805. If a court finds, in a final judgment, that the peer review
38 resulting in the 805 report was conducted in bad faith and the
39 licensee who is the subject of the report notifies the board of that
40 finding, the board shall include that finding in the central file. For

1 purposes of this paragraph, “peer review” has the same meaning
2 as defined in Section 805.

3 (5) Information reported pursuant to Section 805.01, including
4 any explanatory or exculpatory information submitted by the
5 licensee pursuant to subdivision (b) of that section.

6 (b) (1) Each board shall prescribe and promulgate forms on
7 which members of the public and other licensees or certificate
8 holders may file written complaints to the board alleging any act
9 of misconduct in, or connected with, the performance of
10 professional services by the licensee.

11 (2) If a board, or division thereof, a committee, or a panel has
12 failed to act upon a complaint or report within five years, or has
13 found that the complaint or report is without merit, the central file
14 shall be purged of information relating to the complaint or report.

15 (3) Notwithstanding this subdivision, the Board of Psychology,
16 the Board of Behavioral Sciences, and the Respiratory Care Board
17 of California shall maintain complaints or reports as long as each
18 board deems necessary.

19 (c) (1) The contents of any central file that are not public
20 records under any other provision of law shall be confidential
21 except that the licensee involved, or his or her counsel or
22 representative, shall have the right to inspect and have copies made
23 of his or her complete file except for the provision that may
24 disclose the identity of an information source. For the purposes of
25 this section, a board may protect an information source by
26 providing a copy of the material with only those deletions necessary
27 to protect the identity of the source or by providing a
28 comprehensive summary of the substance of the material.
29 Whichever method is used, the board shall ensure that full
30 disclosure is made to the subject of any personal information that
31 could reasonably in any way reflect or convey anything detrimental,
32 disparaging, or threatening to a licensee’s reputation, rights,
33 benefits, privileges, or qualifications, or be used by a board to
34 make a determination that would affect a licensee’s rights, benefits,
35 privileges, or qualifications. The information required to be
36 disclosed pursuant to Section 803.1 shall not be considered among
37 the contents of a central file for the purposes of this subdivision.

38 (2) The licensee may, but is not required to, submit any
39 additional exculpatory or explanatory statement or other
40 information that the board shall include in the central file.

1 (3) Each board may permit any law enforcement or regulatory
2 agency when required for an investigation of unlawful activity or
3 for licensing, certification, or regulatory purposes to inspect and
4 have copies made of that licensee's file, unless the disclosure is
5 otherwise prohibited by law.

6 (4) These disclosures shall effect no change in the confidential
7 status of these records.

8 SEC. 10. Section 803.1 of the Business and Professions Code
9 is amended to read:

10 803.1. (a) Notwithstanding any other law, the Medical Board
11 of California, the Osteopathic Medical Board of California, the
12 California Board of Podiatric Medicine, and the Physician Assistant
13 Board shall disclose to an inquiring member of the public
14 information regarding any enforcement actions taken against a
15 licensee, including a former licensee, by the board or by another
16 state or jurisdiction, including all of the following:

17 (1) Temporary restraining orders issued.

18 (2) Interim suspension orders issued.

19 (3) Revocations, suspensions, probations, or limitations on
20 practice ordered by the board, including those made part of a
21 probationary order or stipulated agreement.

22 (4) Public letters of reprimand issued.

23 (5) Infractions, citations, or fines imposed.

24 (b) Notwithstanding any other law, in addition to the information
25 provided in subdivision (a), the Medical Board of California, the
26 Osteopathic Medical Board of California, the California Board of
27 Podiatric Medicine, and the Physician Assistant Board shall
28 disclose to an inquiring member of the public all of the following:

29 (1) Civil judgments in any amount, whether or not vacated by
30 a settlement after entry of the judgment, that were not reversed on
31 appeal and arbitration awards in any amount of a claim or action
32 for damages for death or personal injury caused by the physician's
33 and surgeon's negligence, error, or omission in practice, or by his
34 or her rendering of unauthorized professional services.

35 (2) (A) All settlements in the possession, custody, or control
36 of the board shall be disclosed for a licensee in the low-risk
37 category if there are three or more settlements for that licensee
38 within the last 10 years, except for settlements by a licensee
39 regardless of the amount paid where (i) the settlement is made as
40 a part of the settlement of a class claim, (ii) the licensee paid in

1 settlement of the class claim the same amount as the other licensees
2 in the same class or similarly situated licensees in the same class,
3 and (iii) the settlement was paid in the context of a case where the
4 complaint that alleged class liability on behalf of the licensee also
5 alleged a products liability class action cause of action. All
6 settlements in the possession, custody, or control of the board shall
7 be disclosed for a licensee in the high-risk category if there are
8 four or more settlements for that licensee within the last 10 years
9 except for settlements by a licensee regardless of the amount paid
10 where (i) the settlement is made as a part of the settlement of a
11 class claim, (ii) the licensee paid in settlement of the class claim
12 the same amount as the other licensees in the same class or
13 similarly situated licensees in the same class, and (iii) the
14 settlement was paid in the context of a case where the complaint
15 that alleged class liability on behalf of the licensee also alleged a
16 products liability class action cause of action. Classification of a
17 licensee in either a “high-risk category” or a “low-risk category”
18 depends upon the specialty or subspecialty practiced by the licensee
19 and the designation assigned to that specialty or subspecialty by
20 the Medical Board of California, as described in subdivision (f).
21 For the purposes of this paragraph, “settlement” means a settlement
22 of an action described in paragraph (1) entered into by the licensee
23 on or after January 1, 2003, in an amount of thirty thousand dollars
24 (\$30,000) or more.

25 (B) The board shall not disclose the actual dollar amount of a
26 settlement but shall put the number and amount of the settlement
27 in context by doing the following:

28 (i) Comparing the settlement amount to the experience of other
29 licensees within the same specialty or subspecialty, indicating if
30 it is below average, average, or above average for the most recent
31 10-year period.

32 (ii) Reporting the number of years the licensee has been in
33 practice.

34 (iii) Reporting the total number of licensees in that specialty or
35 subspecialty, the number of those who have entered into a
36 settlement agreement, and the percentage that number represents
37 of the total number of licensees in the specialty or subspecialty.

38 (3) Current American Board of Medical Specialties certification
39 or board equivalent as certified by the Medical Board of California,

1 the Osteopathic Medical Board of California, or the California
2 Board of Podiatric Medicine.

3 (4) Approved postgraduate training.

4 (5) Status of the license of a licensee. By January 1, 2004, the
5 Medical Board of California, the Osteopathic Medical Board of
6 California, and the California Board of Podiatric Medicine shall
7 adopt regulations defining the status of a licensee. The board shall
8 employ this definition when disclosing the status of a licensee
9 pursuant to Section 2027.

10 (6) Any summaries of hospital disciplinary actions that result
11 in the termination or revocation of a licensee's staff privileges for
12 medical disciplinary cause or reason, unless a court finds, in a final
13 judgment, that the peer review resulting in the disciplinary action
14 was conducted in bad faith and the licensee notifies the board of
15 that finding. In addition, any exculpatory or explanatory statements
16 submitted by the licensee electronically pursuant to subdivision
17 (f) of that section shall be disclosed. For purposes of this paragraph,
18 "peer review" has the same meaning as defined in Section 805.

19 (c) Notwithstanding any other law, the Medical Board of
20 California, the Osteopathic Medical Board of California, the
21 California Board of Podiatric Medicine, and the Physician Assistant
22 Board shall disclose to an inquiring member of the public
23 information received regarding felony convictions of a physician
24 and surgeon or doctor of podiatric medicine.

25 (d) The Medical Board of California, the Osteopathic Medical
26 Board of California, the California Board of Podiatric Medicine,
27 and the Physician Assistant Board may formulate appropriate
28 disclaimers or explanatory statements to be included with any
29 information released, and may by regulation establish categories
30 of information that need not be disclosed to an inquiring member
31 of the public because that information is unreliable or not
32 sufficiently related to the licensee's professional practice. The
33 Medical Board of California, the Osteopathic Medical Board of
34 California, the California Board of Podiatric Medicine, and the
35 Physician Assistant Board shall include the following statement
36 when disclosing information concerning a settlement:

37
38 "Some studies have shown that there is no significant correlation
39 between malpractice history and a doctor's competence. At the
40 same time, the State of California believes that consumers should

1 have access to malpractice information. In these profiles, the State
2 of California has given you information about both the malpractice
3 settlement history for the doctor's specialty and the doctor's history
4 of settlement payments only if in the last 10 years, the doctor, if
5 in a low-risk specialty, has three or more settlements or the doctor,
6 if in a high-risk specialty, has four or more settlements. The State
7 of California has excluded some class action lawsuits because
8 those cases are commonly related to systems issues such as product
9 liability, rather than questions of individual professional
10 competence and because they are brought on a class basis where
11 the economic incentive for settlement is great. The State of
12 California has placed payment amounts into three statistical
13 categories: below average, average, and above average compared
14 to others in the doctor's specialty. To make the best health care
15 decisions, you should view this information in perspective. You
16 could miss an opportunity for high-quality care by selecting a
17 doctor based solely on malpractice history.

18 When considering malpractice data, please keep in mind:

19 Malpractice histories tend to vary by specialty. Some specialties
20 are more likely than others to be the subject of litigation. This
21 report compares doctors only to the members of their specialty,
22 not to all doctors, in order to make an individual doctor's history
23 more meaningful.

24 This report reflects data only for settlements made on or after
25 January 1, 2003. Moreover, it includes information concerning
26 those settlements for a 10-year period only. Therefore, you should
27 know that a doctor may have made settlements in the 10 years
28 immediately preceding January 1, 2003, that are not included in
29 this report. After January 1, 2013, for doctors practicing less than
30 10 years, the data covers their total years of practice. You should
31 take into account the effective date of settlement disclosure as well
32 as how long the doctor has been in practice when considering
33 malpractice averages.

34 The incident causing the malpractice claim may have happened
35 years before a payment is finally made. Sometimes, it takes a long
36 time for a malpractice lawsuit to settle. Some doctors work
37 primarily with high-risk patients. These doctors may have
38 malpractice settlement histories that are higher than average
39 because they specialize in cases or patients who are at very high
40 risk for problems.

1 Settlement of a claim may occur for a variety of reasons that do
2 not necessarily reflect negatively on the professional competence
3 or conduct of the doctor. A payment in settlement of a medical
4 malpractice action or claim should not be construed as creating a
5 presumption that medical malpractice has occurred.

6 You may wish to discuss information in this report and the
7 general issue of malpractice with your doctor.”
8

9 (e) The Medical Board of California, the Osteopathic Medical
10 Board of California, the California Board of Podiatric Medicine,
11 and the Physician Assistant Board shall, by regulation, develop
12 standard terminology that accurately describes the different types
13 of disciplinary filings and actions to take against a licensee as
14 described in paragraphs (1) to (5), inclusive, of subdivision (a). In
15 providing the public with information about a licensee via the
16 Internet pursuant to Section 2027, the Medical Board of California,
17 the Osteopathic Medical Board of California, the California Board
18 of Podiatric Medicine, and the Physician Assistant Board shall not
19 use the terms “enforcement,” “discipline,” or similar language
20 implying a sanction unless the physician and surgeon has been the
21 subject of one of the actions described in paragraphs (1) to (5),
22 inclusive, of subdivision (a).

23 (f) The Medical Board of California shall adopt regulations no
24 later than July 1, 2003, designating each specialty and subspecialty
25 practice area as either high risk or low risk. In promulgating these
26 regulations, the board shall consult with commercial underwriters
27 of medical malpractice insurance companies, health care systems
28 that self-insure physicians and surgeons, and representatives of
29 the California medical specialty societies. The board shall utilize
30 the carriers’ statewide data to establish the two risk categories and
31 the averages required by subparagraph (B) of paragraph (2) of
32 subdivision (b). Prior to issuing regulations, the board shall
33 convene public meetings with the medical malpractice carriers,
34 self-insurers, and specialty representatives.

35 (g) The Medical Board of California, the Osteopathic Medical
36 Board of California, the California Board of Podiatric Medicine,
37 and the Physician Assistant Board shall provide each licensee,
38 including a former licensee under subdivision (a), with a copy of
39 the text of any proposed public disclosure authorized by this section
40 prior to release of the disclosure to the public. The licensee shall

1 have 10 working days from the date the board provides the copy
2 of the proposed public disclosure to propose corrections of factual
3 inaccuracies. Nothing in this section shall prevent the board from
4 disclosing information to the public prior to the expiration of the
5 10-day period.

6 (h) Pursuant to subparagraph (A) of paragraph (2) of subdivision
7 (b), the specialty or subspecialty information required by this
8 section shall group physicians by specialty board recognized
9 pursuant to paragraph (5) of subdivision (h) of Section 651 unless
10 a different grouping would be more valid and the board, in its
11 statement of reasons for its regulations, explains why the validity
12 of the grouping would be more valid.

13 (i) On and after July 1, 2018, the Medical Board of California
14 and the Osteopathic Medical Board of California shall provide the
15 information described in subdivision (d) of Section 2228.1, with
16 respect to licensees on probation and licensees practicing under
17 probationary licenses, to an inquiring member of the public and
18 on any board documents, such as newsletters, informing the public
19 of individual probation orders and probationary licenses.

20 SEC. 11. Section 805 of the Business and Professions Code is
21 amended to read:

22 805. (a) As used in this section, the following terms have the
23 following definitions:

24 (1) (A) “Peer review” means both of the following:

25 (i) A process in which a peer review body reviews the basic
26 qualifications, staff privileges, employment, medical outcomes,
27 or professional conduct of licentiates to make recommendations
28 for quality improvement and education, if necessary, in order to
29 do either or both of the following:

30 (I) Determine whether a licentiate may practice or continue to
31 practice in a health care facility, clinic, or other setting providing
32 medical services, and, if so, to determine the parameters of that
33 practice.

34 (II) Assess and improve the quality of care rendered in a health
35 care facility, clinic, or other setting providing medical services.

36 (ii) Any other activities of a peer review body as specified in
37 subparagraph (B).

38 (B) “Peer review body” includes:

39 (i) A medical or professional staff of any health care facility or
40 clinic licensed under Division 2 (commencing with Section 1200)

1 of the Health and Safety Code or of a facility certified to participate
2 in the federal Medicare program as an ambulatory surgical center.

3 (ii) A health care service plan licensed under Chapter 2.2
4 (commencing with Section 1340) of Division 2 of the Health and
5 Safety Code or a disability insurer that contracts with licentiates
6 to provide services at alternative rates of payment pursuant to
7 Section 10133 of the Insurance Code.

8 (iii) Any medical, psychological, marriage and family therapy,
9 social work, professional clinical counselor, dental, midwifery, or
10 podiatric professional society having as members at least 25 percent
11 of the eligible licentiates in the area in which it functions (which
12 must include at least one county), which is not organized for profit
13 and which has been determined to be exempt from taxes pursuant
14 to Section 23701 of the Revenue and Taxation Code.

15 (iv) A committee organized by any entity consisting of or
16 employing more than 25 licentiates of the same class that functions
17 for the purpose of reviewing the quality of professional care
18 provided by members or employees of that entity.

19 (2) "Licentiate" means a physician and surgeon, doctor of
20 podiatric medicine, clinical psychologist, marriage and family
21 therapist, clinical social worker, professional clinical counselor,
22 dentist, licensed midwife, or physician assistant. "Licentiate" also
23 includes a person authorized to practice medicine pursuant to
24 Section 2113 or 2168.

25 (3) "Agency" means the relevant state licensing agency having
26 regulatory jurisdiction over the licentiates listed in paragraph (2).

27 (4) "Staff privileges" means any arrangement under which a
28 licentiate is allowed to practice in or provide care for patients in
29 a health facility. Those arrangements shall include, but are not
30 limited to, full staff privileges, active staff privileges, limited staff
31 privileges, auxiliary staff privileges, provisional staff privileges,
32 temporary staff privileges, courtesy staff privileges, locum tenens
33 arrangements, and contractual arrangements to provide professional
34 services, including, but not limited to, arrangements to provide
35 outpatient services.

36 (5) "Denial or termination of staff privileges, membership, or
37 employment" includes failure or refusal to renew a contract or to
38 renew, extend, or reestablish any staff privileges, if the action is
39 based on medical disciplinary cause or reason.

1 (6) “Medical disciplinary cause or reason” means that aspect
2 of a licentiate’s competence or professional conduct that is
3 reasonably likely to be detrimental to patient safety or to the
4 delivery of patient care.

5 (7) “805 report” means the written report required under
6 subdivision (b).

7 (b) The chief of staff of a medical or professional staff or other
8 chief executive officer, medical director, or administrator of any
9 peer review body and the chief executive officer or administrator
10 of any licensed health care facility or clinic shall file an 805 report
11 with the relevant agency within 15 days after the effective date on
12 which any of the following occur as a result of an action of a peer
13 review body:

14 (1) A licentiate’s application for staff privileges or membership
15 is denied or rejected for a medical disciplinary cause or reason.

16 (2) A licentiate’s membership, staff privileges, or employment
17 is terminated or revoked for a medical disciplinary cause or reason.

18 (3) Restrictions are imposed, or voluntarily accepted, on staff
19 privileges, membership, or employment for a cumulative total of
20 30 days or more for any 12-month period, for a medical disciplinary
21 cause or reason.

22 (c) If a licentiate takes any action listed in paragraph (1), (2),
23 or (3) after receiving notice of a pending investigation initiated
24 for a medical disciplinary cause or reason or after receiving notice
25 that his or her application for membership or staff privileges is
26 denied or will be denied for a medical disciplinary cause or reason,
27 the chief of staff of a medical or professional staff or other chief
28 executive officer, medical director, or administrator of any peer
29 review body and the chief executive officer or administrator of
30 any licensed health care facility or clinic where the licentiate is
31 employed or has staff privileges or membership or where the
32 licentiate applied for staff privileges or membership, or sought the
33 renewal thereof, shall file an 805 report with the relevant agency
34 within 15 days after the licentiate takes the action.

35 (1) Resigns or takes a leave of absence from membership, staff
36 privileges, or employment.

37 (2) Withdraws or abandons his or her application for staff
38 privileges or membership.

39 (3) Withdraws or abandons his or her request for renewal of
40 staff privileges or membership.

1 (d) For purposes of filing an 805 report, the signature of at least
2 one of the individuals indicated in subdivision (b) or (c) on the
3 completed form shall constitute compliance with the requirement
4 to file the report.

5 (e) An 805 report shall also be filed within 15 days following
6 the imposition of summary suspension of staff privileges,
7 membership, or employment, if the summary suspension remains
8 in effect for a period in excess of 14 days.

9 (f) A copy of the 805 report, and a notice advising the licentiate
10 of his or her right to submit additional statements or other
11 information, electronically or otherwise, pursuant to Section 800,
12 shall be sent by the peer review body to the licentiate named in
13 the report. The notice shall also advise the licentiate that
14 information submitted electronically will be publicly disclosed to
15 those who request the information.

16 The information to be reported in an 805 report shall include the
17 name and license number of the licentiate involved, a description
18 of the facts and circumstances of the medical disciplinary cause
19 or reason, and any other relevant information deemed appropriate
20 by the reporter.

21 A supplemental report shall also be made within 30 days
22 following the date the licentiate is deemed to have satisfied any
23 terms, conditions, or sanctions imposed as disciplinary action by
24 the reporting peer review body. In performing its dissemination
25 functions required by Section 805.5, the agency shall include a
26 copy of a supplemental report, if any, whenever it furnishes a copy
27 of the original 805 report.

28 If another peer review body is required to file an 805 report, a
29 health care service plan is not required to file a separate report
30 with respect to action attributable to the same medical disciplinary
31 cause or reason. If the Medical Board of California or a licensing
32 agency of another state revokes or suspends, without a stay, the
33 license of a physician and surgeon, a peer review body is not
34 required to file an 805 report when it takes an action as a result of
35 the revocation or suspension. If the California Board of Podiatric
36 Medicine or a licensing agency of another state revokes or
37 suspends, without a stay, the license of a doctor of podiatric
38 medicine, a peer review body is not required to file an 805 report
39 when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the California Board of Podiatric Medicine, the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars (\$100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. If the person who is designated or otherwise required to file an 805 report is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the California Board of Podiatric Medicine. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licensee. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, “willful” means a voluntary and intentional violation of a known legal duty.

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances

1 shall exceed fifty thousand dollars (\$50,000) per violation. The
2 fine may be imposed in any civil or administrative action or
3 proceeding brought by or on behalf of any agency having
4 regulatory jurisdiction over the person regarding whom the report
5 was or should have been filed. If the person who is designated or
6 otherwise required to file an 805 report is a licensed physician and
7 surgeon, the action or proceeding shall be brought by the Medical
8 Board of California. If the person who is designated or otherwise
9 required to file an 805 report is a licensed doctor of podiatric
10 medicine, the action or proceeding shall be brought by the
11 California Board of Podiatric Medicine. The fine shall be paid to
12 that agency but not expended until appropriated by the Legislature.
13 The amount of the fine imposed, not exceeding fifty thousand
14 dollars (\$50,000) per violation, shall be proportional to the severity
15 of the failure to report and shall differ based upon written findings,
16 including whether the failure to file caused harm to a patient or
17 created a risk to patient safety; whether the administrator of any
18 peer review body, the chief executive officer or administrator of
19 any health care facility, or any person who is designated or
20 otherwise required by law to file an 805 report exercised due
21 diligence despite the failure to file or whether they knew or should
22 have known that an 805 report would not be filed; and whether
23 there has been a prior failure to file an 805 report. The amount of
24 the fine imposed may also differ based on whether a health care
25 facility is a small or rural hospital as defined in Section 124840
26 of the Health and Safety Code.

27 (m) A health care service plan licensed under Chapter 2.2
28 (commencing with Section 1340) of Division 2 of the Health and
29 Safety Code or a disability insurer that negotiates and enters into
30 a contract with licentiates to provide services at alternative rates
31 of payment pursuant to Section 10133 of the Insurance Code, when
32 determining participation with the plan or insurer, shall evaluate,
33 on a case-by-case basis, licentiates who are the subject of an 805
34 report, and not automatically exclude or deselect these licentiates.

35 ~~(n) State agencies and hospital accrediting agencies shall report~~
36 ~~to the Medical Board of California any peer review incidents~~
37 ~~subject to 805 reporting that are found during an inspection of a~~
38 ~~health care facility or clinic.~~

39 SEC. 12. Section 805.01 of the Business and Professions Code
40 is amended to read:

1 805.01. (a) As used in this section, the following terms have
2 the following definitions:

3 (1) “Agency” has the same meaning as defined in Section 805.

4 (2) “Formal investigation” means an investigation performed
5 by a peer review body based on an allegation that any of the acts
6 listed in paragraphs (1) to (4), inclusive, of subdivision (b)
7 occurred.

8 (3) “Licentiate” has the same meaning as defined in Section
9 805.

10 (4) “Peer review body” has the same meaning as defined in
11 Section 805.

12 (b) The chief of staff of a medical or professional staff or other
13 chief executive officer, medical director, or administrator of any
14 peer review body and the chief executive officer or administrator
15 of any licensed health care facility or clinic shall file a report with
16 the relevant agency within 15 days after a peer review body makes
17 a final decision or recommendation regarding the disciplinary
18 action, as specified in subdivision (b) of Section 805, resulting in
19 a final proposed action to be taken against a licentiate based on
20 the peer review body’s determination, following formal
21 investigation of the licentiate, that any of the acts listed in
22 paragraphs (1) to (4), inclusive, may have occurred, regardless of
23 whether a hearing is held pursuant to Section 809.2. The licentiate
24 shall receive a notice of the proposed action as set forth in Section
25 809.1, which shall also include a notice advising the licentiate of
26 the right to submit additional explanatory or exculpatory statements
27 electronically or otherwise.

28 (1) Incompetence, or gross or repeated deviation from the
29 standard of care involving death or serious bodily injury to one or
30 more patients, to the extent or in such a manner as to be dangerous
31 or injurious to any person or to the public. This paragraph shall
32 not be construed to affect or require the imposition of immediate
33 suspension pursuant to Section 809.5.

34 (2) The use of, or prescribing for or administering to himself or
35 herself, any controlled substance; or the use of any dangerous drug,
36 as defined in Section 4022, or of alcoholic beverages, to the extent
37 or in such a manner as to be dangerous or injurious to the licentiate,
38 any other person, or the public, or to the extent that such use
39 impairs the ability of the licentiate to practice safely.

1 (3) Repeated acts of clearly excessive prescribing, furnishing,
2 or administering of controlled substances or repeated acts of
3 prescribing, dispensing, or furnishing of controlled substances
4 without a good faith effort prior examination of the patient and
5 medical reason therefor. However, in no event shall a physician
6 and surgeon prescribing, furnishing, or administering controlled
7 substances for intractable pain, consistent with lawful prescribing,
8 be reported for excessive prescribing and prompt review of the
9 applicability of these provisions shall be made in any complaint
10 that may implicate these provisions.

11 (4) Sexual misconduct with one or more patients during a course
12 of treatment or an examination.

13 (c) The relevant agency shall be entitled to inspect and copy the
14 following documents in the record of any formal investigation
15 required to be reported pursuant to subdivision (b):

16 (1) Any statement of charges.

17 (2) Any document, medical chart, or exhibit.

18 (3) Any opinions, findings, or conclusions.

19 (4) Any certified copy of medical records, as permitted by other
20 applicable law.

21 (d) The report provided pursuant to subdivision (b) and the
22 information disclosed pursuant to subdivision (c) shall be kept
23 confidential and shall not be subject to discovery, except that the
24 information may be reviewed as provided in subdivision (c) of
25 Section 800 and may be disclosed in any subsequent disciplinary
26 hearing conducted pursuant to the Administrative Procedure Act
27 (Chapter 5 (commencing with Section 11500) of Part 1 of Division
28 3 of Title 2 of the Government Code).

29 (e) The report required under this section shall be in addition
30 to any report required under Section 805.

31 (f) A peer review body shall not be required to make a report
32 pursuant to this section if that body does not make a final decision
33 or recommendation regarding the disciplinary action to be taken
34 against a licensee based on the body's determination that any of
35 the acts listed in paragraphs (1) to (4), inclusive, of subdivision
36 (b) may have occurred.

37 (g) A willful failure to file a report pursuant to this section by
38 any person who is designated or otherwise required by law to file
39 a report is punishable by a fine not to exceed one hundred thousand
40 dollars (\$100,000) per violation. The fine may be imposed in any

1 civil or administrative action or proceeding brought by or on behalf
2 of any agency having regulatory jurisdiction over the person who
3 filed or should have filed the report. If the person who is designated
4 or otherwise required to file a report is a licensed physician and
5 surgeon, the action or proceeding shall be brought by the Medical
6 Board of California. The fine shall be paid to that agency. A
7 violation of this subdivision may constitute unprofessional conduct
8 by the licensee. A person who is alleged to have violated this
9 subdivision may assert any defense available at law. As used in
10 this subdivision, “willful” means a voluntary and intentional
11 violation of a known legal duty.

12 (h) Except as otherwise provided in subdivision (g), any failure
13 by the administrator of any peer review body, the chief executive
14 officer or administrator of any health care facility, or any person
15 who is designated or otherwise required by law to file a report
16 pursuant to this section, shall be punishable by a fine that under
17 no circumstances shall exceed fifty thousand dollars (\$50,000) per
18 violation. The fine may be imposed in any civil or administrative
19 action or proceeding brought by or on behalf of any agency having
20 regulatory jurisdiction over the person who filed or should have
21 filed the report. If the person who is designated or otherwise
22 required to file a report is a licensed physician and surgeon, the
23 action or proceeding shall be brought by the Medical Board of
24 California. The fine shall be paid to that agency. The amount of
25 the fine imposed, not exceeding fifty thousand dollars (\$50,000)
26 per violation, shall be proportional to the severity of the failure to
27 report and shall differ based upon written findings, including (i)
28 whether the failure to file caused harm to a patient or created a
29 risk to patient safety, (ii) whether the administrator of any peer
30 review body, the chief executive officer or administrator of any
31 health care facility, or any person who is designated or otherwise
32 required by law to file a report exercised due diligence despite the
33 failure to file or whether they knew or should have known that a
34 report would not be filed, and (3) whether there has been a prior
35 failure to file a report. The amount of the fine imposed may also
36 differ based on whether a health care facility is a small or rural
37 hospital as defined in Section 124840 of the Health and Safety
38 Code.

39 ~~(i) State agencies and hospital accrediting agencies shall report~~
40 ~~to the Medical Board of California any peer review incidents~~

1 ~~subject to Section 805.01 reporting that are found during an~~
2 ~~inspection of a health care facility or clinic.~~

3 SEC. 13. Section 805.1 of the Business and Professions Code
4 is amended to read:

5 805.1. (a) The Medical Board of California, the California
6 Board of Podiatric Medicine, the Osteopathic Medical Board of
7 California, and the Dental Board of California shall be entitled to
8 inspect and copy the following documents in the record of any
9 disciplinary proceeding resulting in action that is required to be
10 reported pursuant to Section 805:

- 11 (1) Any statement of charges.
12 (2) Any document, medical chart, or exhibits in evidence.
13 (3) Any opinion, findings, or conclusions.
14 (4) Any certified copy of medical records, as permitted by other
15 applicable law.

16 (b) The information so disclosed shall be kept confidential and
17 not subject to discovery, in accordance with Section 800, except
18 that it may be reviewed, as provided in subdivision (c) of Section
19 800, and may be disclosed in any subsequent disciplinary hearing
20 conducted pursuant to the Administrative Procedure Act (Chapter
21 5 (commencing with Section 11500) of Part 1 of Division 3 of
22 Title 2 of the Government Code).

23 SEC. 14. Section 805.5 of the Business and Professions Code
24 is amended to read:

25 805.5. (a) Prior to granting or renewing staff privileges for
26 any physician and surgeon, psychologist, podiatrist, or dentist, any
27 health facility licensed pursuant to Division 2 (commencing with
28 Section 1200) of the Health and Safety Code, any health care
29 service plan or medical care foundation, the medical staff of the
30 institution, a facility certified to participate in the federal Medicare
31 Program as an ambulatory surgical center, or an outpatient setting
32 accredited pursuant to Section 1248.1 of the Health and Safety
33 Code shall request a report from the Medical Board of California,
34 the Board of Psychology, the California Board of Podiatric
35 Medicine, the Osteopathic Medical Board of California, or the
36 Dental Board of California to determine if any report has been
37 made pursuant to Section 805 indicating that the applying physician
38 and surgeon, psychologist, podiatrist, or dentist has been denied
39 staff privileges, been removed from a medical staff, or had his or
40 her staff privileges restricted as provided in Section 805. The

1 request shall include the name and California license number of
2 the physician and surgeon, psychologist, podiatrist, or dentist.
3 Furnishing of a copy of the 805 report shall not cause the 805
4 report to be a public record.

5 (b) Upon a request made by, or on behalf of, an institution
6 described in subdivision (a) or its medical staff the board shall
7 furnish a copy of any report made pursuant to Section 805 as well
8 as any additional exculpatory or explanatory information submitted
9 electronically to the board by the licensee pursuant to subdivision
10 (f) of that section. However, the board shall not send a copy of a
11 report (1) if the denial, removal, or restriction was imposed solely
12 because of the failure to complete medical records, (2) if the board
13 has found the information reported is without merit, (3) if a court
14 finds, in a final judgment, that the peer review, as defined in
15 Section 805, resulting in the report was conducted in bad faith and
16 the licensee who is the subject of the report notifies the board of
17 that finding, or (4) if a period of three years has elapsed since the
18 report was submitted. This three-year period shall be tolled during
19 any period the licensee has obtained a judicial order precluding
20 disclosure of the report, unless the board is finally and permanently
21 precluded by judicial order from disclosing the report. If a request
22 is received by the board while the board is subject to a judicial
23 order limiting or precluding disclosure, the board shall provide a
24 disclosure to any qualified requesting party as soon as practicable
25 after the judicial order is no longer in force.

26 If the board fails to advise the institution within 30 working days
27 following its request for a report required by this section, the
28 institution may grant or renew staff privileges for the physician
29 and surgeon, psychologist, podiatrist, or dentist.

30 (c) Any institution described in subdivision (a) or its medical
31 staff that violates subdivision (a) is guilty of a misdemeanor and
32 shall be punished by a fine of not less than two hundred dollars
33 (\$200) nor more than one thousand two hundred dollars (\$1,200).

34 SEC. 15. Section 805.6 of the Business and Professions Code
35 is amended to read:

36 805.6. (a) The Medical Board of California, the California
37 Board of Podiatric Medicine, the Osteopathic Medical Board of
38 California, and the Dental Board of California shall establish a
39 system of electronic notification that is either initiated by the board
40 or can be accessed by qualified subscribers, and that is designed

1 to achieve early notification to qualified recipients of the existence
2 of new reports that are filed pursuant to Section 805.

3 (b) The State Department of Health Care Services shall notify
4 the appropriate licensing agency of any reporting violations
5 pursuant to Section 805.

6 (c) The Department of Managed Health Care shall notify the
7 appropriate licensing agency of any reporting violations pursuant
8 to Section 805.

9 SEC. 16. Section 810 of the Business and Professions Code is
10 amended to read:

11 810. (a) It shall constitute unprofessional conduct and grounds
12 for disciplinary action, including suspension or revocation of a
13 license or certificate, for a health care professional to do any of
14 the following in connection with his or her professional activities:

15 (1) Knowingly present or cause to be presented any false or
16 fraudulent claim for the payment of a loss under a contract of
17 insurance.

18 (2) Knowingly prepare, make, or subscribe any writing, with
19 intent to present or use the same, or to allow it to be presented or
20 used in support of any false or fraudulent claim.

21 (b) It shall constitute cause for revocation or suspension of a
22 license or certificate for a health care professional to engage in
23 any conduct prohibited under Section 1871.4 of the Insurance Code
24 or Section 549 or 550 of the Penal Code.

25 (c) (1) It shall constitute cause for automatic suspension of a
26 license or certificate issued pursuant to Chapter 4 (commencing
27 with Section 1600), Chapter 5 (commencing with Section 2000),
28 Chapter 6.6 (commencing with Section 2900), Chapter 7
29 (commencing with Section 3000), or Chapter 9 (commencing with
30 Section 4000), or pursuant to the Chiropractic Act or the
31 Osteopathic Act, if a licensee or certificate holder has been
32 convicted of any felony involving fraud committed by the licensee
33 or certificate holder in conjunction with providing benefits covered
34 by worker's compensation insurance, or has been convicted of any
35 felony involving Medi-Cal fraud committed by the licensee or
36 certificate holder in conjunction with the Medi-Cal program,
37 including the Denti-Cal element of the Medi-Cal program, pursuant
38 to Chapter 7 (commencing with Section 14000), or Chapter 8
39 (commencing with Section 14200), of Part 3 of Division 9 of the
40 Welfare and Institutions Code. The board shall convene a

1 disciplinary hearing to determine whether or not the license or
2 certificate shall be suspended, revoked, or some other disposition
3 shall be considered, including, but not limited to, revocation with
4 the opportunity to petition for reinstatement, suspension, or other
5 limitations on the license or certificate as the board deems
6 appropriate.

7 (2) It shall constitute cause for automatic suspension and for
8 revocation of a license or certificate issued pursuant to Chapter 4
9 (commencing with Section 1600), Chapter 5 (commencing with
10 Section 2000), Chapter 6.6 (commencing with Section 2900),
11 Chapter 7 (commencing with Section 3000), or Chapter 9
12 (commencing with Section 4000), or pursuant to the Chiropractic
13 Act or the Osteopathic Act, if a licensee or certificate holder has
14 more than one conviction of any felony arising out of separate
15 prosecutions involving fraud committed by the licensee or
16 certificate holder in conjunction with providing benefits covered
17 by worker's compensation insurance, or in conjunction with the
18 Medi-Cal program, including the Denti-Cal element of the
19 Medi-Cal program pursuant to Chapter 7 (commencing with
20 Section 14000), or Chapter 8 (commencing with Section 14200),
21 of Part 3 of Division 9 of the Welfare and Institutions Code. The
22 board shall convene a disciplinary hearing to revoke the license
23 or certificate and an order of revocation shall be issued unless the
24 board finds mitigating circumstances to order some other
25 disposition.

26 (3) It is the intent of the Legislature that paragraph (2) apply to
27 a licensee or certificate holder who has one or more convictions
28 prior to January 1, 2004, as provided in this subdivision.

29 (4) Nothing in this subdivision shall preclude a board from
30 suspending or revoking a license or certificate pursuant to any
31 other provision of law.

32 (5) "Board," as used in this subdivision, means the Dental Board
33 of California, the Medical Board of California, the California Board
34 of Podiatric Medicine, the Board of Psychology, the State Board
35 of Optometry, the California State Board of Pharmacy, the
36 Osteopathic Medical Board of California, and the State Board of
37 Chiropractic Examiners.

38 (6) "More than one conviction," as used in this subdivision,
39 means that the licensee or certificate holder has one or more
40 convictions prior to January 1, 2004, and at least one conviction

1 on or after that date, or the licensee or certificate holder has two
2 or more convictions on or after January 1, 2004. However, a
3 licensee or certificate holder who has one or more convictions
4 prior to January 1, 2004, but who has no convictions and is
5 currently licensed or holds a certificate after that date, does not
6 have “more than one conviction” for the purposes of this
7 subdivision.

8 (d) As used in this section, health care professional means any
9 person licensed or certified pursuant to this division, or licensed
10 pursuant to the Osteopathic Initiative Act, or the Chiropractic
11 Initiative Act.

12 SEC. 17. Section 2001 of the Business and Professions Code
13 is amended to read:

14 2001. (a) There is in the Department of Consumer Affairs a
15 Medical Board of California that consists of 15 members, 7 of
16 whom shall be public members.

17 (b) The Governor shall appoint 13 members to the board, subject
18 to confirmation by the Senate, 5 of whom shall be public members.
19 The Senate Committee on Rules and the Speaker of the Assembly
20 shall each appoint a public member.

21 (c) This section shall remain in effect only until January 1, 2022,
22 and as of that date is repealed. Notwithstanding any other law, the
23 repeal of this section renders the board subject to review by the
24 appropriate policy committees of the Legislature.

25 ~~SEC. 18. Section 2006 of the Business and Professions Code~~
26 ~~is amended to read:~~

27 ~~2006. (a) Any reference in this chapter to an investigation by~~
28 ~~the board shall be deemed to refer to an investigation conducted~~
29 ~~by employees of the Health Quality Investigation Unit within the~~
30 ~~Department of Consumer Affairs Division of Investigation.~~

31 ~~SEC. 19.~~

32 SEC. 18. Section 2008 of the Business and Professions Code
33 is amended to read:

34 2008. The board may appoint panels from its members for the
35 purpose of fulfilling the obligations established in subdivision (c)
36 of Section 2004. Any panel appointed under this section shall at
37 no time be comprised of less than four members and the number
38 of public members assigned to the panel shall not exceed the
39 number of licensed physician and surgeon members assigned to
40 the panel. Each panel shall annually elect a chair and a vice chair.

1 ~~SEC. 20.~~

2 *SEC. 19.* Section 2020 of the Business and Professions Code
3 is amended to read:

4 2020. (a) The board, by and with the approval of the director,
5 may employ an executive director exempt from the provisions of
6 the Civil Service Act and may also employ investigators, legal
7 counsel, medical consultants, and other assistance as it may deem
8 necessary to carry this chapter into effect. The board may fix the
9 compensation to be paid for services subject to the provisions of
10 applicable state laws and regulations and may incur other expenses
11 as it may deem necessary. Investigators employed by the board
12 shall be provided special training in investigating medical practice
13 activities.

14 (b) The Attorney General shall act as legal counsel for the board
15 for any judicial and administrative proceedings and his or her
16 services shall be a charge against it.

17 (c) This section shall remain in effect only until January 1, 2022,
18 and as of that date is repealed.

19 ~~SEC. 21.~~

20 *SEC. 20.* Section 2026 is added to the Business and Professions
21 Code, to read:

22 2026. The board shall initiate the process of adopting
23 regulations on or before January 1, 2019, to require its licentiates
24 and registrants to provide notice to their clients or patients that the
25 practitioner is licensed or registered in this state by the board, that
26 the practitioner's license can be checked, and that complaints
27 against the practitioner can be made through the board's Internet
28 Web site or by contacting the board.

29 ~~SEC. 22.~~

30 *SEC. 21.* Section 2052.5 of the Business and Professions Code
31 is repealed.

32 ~~SEC. 23.~~

33 *SEC. 22.* Section 2054 of the Business and Professions Code
34 is amended to read:

35 2054. (a) Any person who uses in any sign, business card, or
36 letterhead, or, in an advertisement, the words "doctor" or
37 "physician," the letters or prefix "Dr.," the initials "M.D.," or any
38 other terms or letters indicating or implying that he or she is a
39 physician and surgeon, physician, surgeon, or practitioner under
40 the terms of this or any other law, or that he or she is entitled to

1 practice hereunder, or who represents or holds himself or herself
2 out as a physician and surgeon, physician, surgeon, or practitioner
3 under the terms of this or any other law, without having at the time
4 of so doing a valid, unrevoked, and unsuspended certificate as a
5 physician and surgeon under this chapter, is guilty of a
6 misdemeanor.

7 (b) Notwithstanding subdivision (a), any of the following
8 persons may use the words “doctor” or “physician,” the letters or
9 prefix “Dr.,” or the initials “M.D.”:

10 (1) A graduate of a medical school approved or recognized by
11 the board while enrolled in a postgraduate training program
12 approved by the board.

13 (2) A graduate of a medical school who does not have a
14 certificate as a physician and surgeon under this chapter if he or
15 she meets all of the following requirements:

16 (A) If issued a license to practice medicine in any jurisdiction,
17 has not had that license revoked or suspended by that jurisdiction.

18 (B) Does not otherwise hold himself or herself out as a physician
19 and surgeon entitled to practice medicine in this state except to
20 the extent authorized by this chapter.

21 (C) Does not engage in any of the acts prohibited by Section
22 2060.

23 (3) A person authorized to practice medicine under Section 2111
24 or 2113 subject to the limitations set forth in those sections.

25 ~~SEC. 24.~~

26 *SEC. 23.* Section 2064 of the Business and Professions Code
27 is amended to read:

28 2064. Nothing in this chapter shall be construed to prevent a
29 regularly matriculated student undertaking a course of professional
30 instruction in an approved medical school, or to prevent a foreign
31 medical student who is enrolled in an approved medical school or
32 clinical training program in this state, from engaging in the practice
33 of medicine whenever and wherever prescribed as a part of his or
34 her course of study.

35 ~~SEC. 25.~~

36 *SEC. 24.* Section 2064.5 is added to the Business and
37 Professions Code, to read:

38 2064.5. (a) Within 180 days after enrollment in a
39 board-approved postgraduate training program pursuant to Section
40 2065, medical school graduates shall obtain a physician’s and

1 surgeon's postgraduate training license. To be considered for a
2 postgraduate training license, the applicant shall submit the
3 application forms and primary source documents required by the
4 board, shall successfully pass all required licensing examinations,
5 shall pay the reduced licensing fee, and shall not have committed
6 any act that would be grounds for denial.

7 (1) Each application submitted pursuant to this section shall be
8 made upon a form provided by the board, and each application
9 form shall contain a legal verification to be signed by the applicant
10 verifying under penalty of perjury that the information provided
11 by the applicant is true and correct and that any information in
12 supporting documents provided by the applicant is true and correct.

13 (2) Each application shall include the following:

14 (A) A diploma issued by a board-approved medical school. The
15 requirements of the school shall not have been less than those
16 required under this chapter at the time the diploma was granted or
17 by any preceding medical practice act at the time that the diploma
18 was granted. In lieu of a diploma, the applicant may submit
19 evidence satisfactory to the board of having possessed the same.

20 (B) An official transcript or other official evidence satisfactory
21 to the board showing each approved medical school in which a
22 resident course of professional instruction was pursued covering
23 the minimum requirements for certification as a physician and
24 surgeon, and that a diploma and degree were granted by the school.

25 (C) Other information concerning the professional instruction
26 and preliminary education of the applicant as the board may
27 require.

28 (D) An affidavit showing to the satisfaction of the board that
29 the applicant is the person named in each diploma and transcript
30 that he or she submits, that he or she is the lawful holder thereof,
31 and that the diploma or transcript was procured in the regular
32 course of professional instruction and examination without fraud
33 or misrepresentation.

34 (E) Either fingerprint cards or a copy of a completed Live Scan
35 form from the applicant in order to establish the identity of the
36 applicant and in order to determine whether the applicant has a
37 record of any criminal convictions in this state or in any other
38 jurisdiction, including foreign countries. The information obtained
39 as a result of the fingerprinting of the applicant shall be used in
40 accordance with Section 11105 of the Penal Code, and to determine

1 whether the applicant is subject to denial of licensure under the
2 provisions of Division 1.5 (commencing with Section 475) and
3 Section 2221 of this code.

4 (F) If the medical school graduate graduated from a foreign
5 medical school approved by the board pursuant to Section 2084,
6 an official Educational Commission for Foreign Medical Graduates
7 (ECFMG) Certification Status Report confirming the graduate is
8 ECFMG certified.

9 (b) The physician's and surgeon's postgraduate training license
10 shall be valid until 90 days after the holder has completed 36
11 months of board-approved postgraduate training. The physician's
12 and surgeon's postgraduate training licensee may engage in the
13 practice of medicine only in connection with his or her duties as
14 an intern or resident physician in a board-approved program,
15 including its affiliated sites, or under those conditions as are
16 approved in writing and maintained in the postgraduate training
17 licensee's file by the director of his or her program.

18 (c) The postgraduate training licensee may engage in the practice
19 of medicine in locations authorized by subdivision (b), and as
20 permitted by the Medical Practice Act and other applicable statutes
21 and regulations, including, but not limited to, the following:

22 (1) Diagnose and treat patients.

23 (2) Prescribe medications without a cosigner, including
24 prescriptions for controlled substances, if the training licensee has
25 the appropriate Drug Enforcement Agency registration/permit and
26 is registered with the Department of Justice CURES program.

27 (3) Sign birth certificates without a cosigner.

28 (4) Sign death certificates without a cosigner.

29 (d) The postgraduate training licensee may be disciplined by
30 the board at any time for any of the grounds that would subject
31 the holder of a physician's and surgeon's certificate to discipline.

32 (e) If the medical school graduate fails to obtain a postgraduate
33 training license within 180 days after enrollment in a
34 board-approved postgraduate training program or if the board
35 denies his or her application for a postgraduate training license,
36 all privileges and exemptions under this section shall automatically
37 cease.

38 ~~SEC. 26.~~

39 *SEC. 25.* Section 2065 of the Business and Professions Code
40 is amended to read:

2065. (a) Unless otherwise provided by law, no postgraduate trainee, intern, resident, postdoctoral fellow, or instructor may engage in the practice of medicine, or receive compensation therefor, or offer to engage in the practice of medicine unless he or she holds a valid, unrevoked, and unsuspended physician's and surgeon's certificate issued by the board. However, a graduate of an approved medical school may engage in the practice of medicine whenever and wherever required as a part of a postgraduate training program under the following conditions:

(1) The medical school graduate has taken and passed the board-approved medical licensing examinations required to qualify the applicant to participate in an approved postgraduate training program.

(2) The medical school graduate is registered with the board.

(3) If the medical school graduate graduated from a foreign medical school approved by the board pursuant to Section 2084, the Educational Commission for Foreign Medical Graduates (ECFMG) has submitted an official ECFMG Certification Status Report directly to the board confirming the graduate is ECFMG certified.

(4) The medical school graduate is enrolled in a postgraduate training program approved by the board.

(5) The board-approved postgraduate training program has submitted the required board-approved form to the board documenting the medical school graduate is enrolled in an approved postgraduate training program.

(6) The medical school graduate obtains a physician's and surgeon's postgraduate training license in accordance with Section 2064.5.

(b) A medical school graduate enrolled in an approved first-year postgraduate training program in accordance with this section may engage in the practice of medicine whenever and wherever required as a part of the training program, and may receive compensation for that practice not to exceed 12 months.

(c) A graduate who has completed the first year of postgraduate training may, in an approved residency or fellowship, engage in the practice of medicine whenever and wherever required as part of that residency or fellowship, and may receive compensation for that practice not to exceed 27 months. The resident or fellow shall qualify for, take, and pass the next succeeding written examination

1 for licensure. If the resident or fellow fails to receive a license to
2 practice medicine under this chapter within 27 months from the
3 commencement of the residency or fellowship or if the board denies
4 his or her application for licensure, all privileges and exemptions
5 under this section shall automatically cease.

6 (d) All approved postgraduate training the medical school
7 graduate has participated in the United States or Canada shall count
8 toward the 39-month license exemption.

9 (e) A medical school graduate from a medical school approved
10 by the board shall have successfully completed a minimum of 36
11 months of approved postgraduate training with at least 24
12 consecutive months in the same program, to be eligible for a
13 California physician's and surgeon's certificate.

14 ~~SEC. 27.~~

15 *SEC. 26.* Section 2066 of the Business and Professions Code
16 is repealed.

17 ~~SEC. 28.~~

18 *SEC. 27.* Section 2066.5 of the Business and Professions Code
19 is amended to read:

20 2066.5. (a) The pilot program authorized by this section shall
21 be known and may be cited as the University of California at Los
22 Angeles David Geffen School of Medicine's International Medical
23 Graduate Pilot Program.

24 (b) Nothing in this chapter shall be construed to prohibit a
25 foreign medical graduate from engaging in the practice of medicine
26 when required as part of the pilot program authorized by this
27 section.

28 (c) There is currently a preresidency training program at the
29 University of California, Los Angeles David Geffen School of
30 Medicine, Department of Family Medicine, hereafter referred to
31 as UCLA, for selected international medical graduates (IMGs).
32 Participation in the pilot program authorized by this section shall
33 be at the option of UCLA. This section authorizes those IMGs,
34 through the new pilot program authorized by this section, to
35 receive, through the existing program, hands-on clinical instruction.
36 The pilot program, as administered by UCLA, shall include all of
37 the following elements:

38 (1) Each pilot program participant shall have done all of the
39 following:

1 (A) Graduated from a medical school recognized by the Medical
2 Board of California at the time of selection.

3 (B) Taken and passed the United States Medical Licensing
4 Examination Steps 1 and 2 (Clinical Knowledge and Clinical
5 Science).

6 (C) Submitted an application and materials to the Educational
7 Commission for Foreign Medical Graduates.

8 (2) A pilot program participant shall receive all clinical
9 instruction at health care facilities operated by the University of
10 California, Los Angeles, or other approved UCLA-designated
11 teaching sites, which shall be hospitals or clinics with either a
12 signed formal affiliation agreement with UCLA or a signed letter
13 of agreement.

14 (3) Participation of a trainee in clinical instruction offered by
15 the pilot program shall not generally exceed 16 weeks. However,
16 at the discretion of UCLA, an additional eight weeks of clinical
17 instruction may be granted. In no event shall a participant receive
18 more than 24 weeks of clinical instruction under the pilot program.

19 (4) The clinical instruction shall be supervised by licensed
20 physicians on faculty at UCLA or faculty affiliated with UCLA
21 as specified in an approved affiliation agreement between UCLA
22 and the affiliated entity.

23 (5) The clinical instruction shall be provided pursuant to written
24 affiliation agreements for clinical instruction of trainees established
25 by UCLA.

26 (6) The supervising faculty shall evaluate each participant on a
27 regular basis and shall document the completion of each aspect of
28 the clinical instruction portion of the program for each participant.

29 (d) UCLA shall provide the board with the names of the
30 participants in the pilot program on an annual basis, or more
31 frequently if necessary to maintain accuracy. Upon a reasonable
32 request of the board, UCLA shall provide additional information
33 such as the courses successfully completed by program participants,
34 the dates of instruction, and other relevant information.

35 (e) On or before January 1, 2018, UCLA is requested to prepare
36 a report for the board and the Legislature. Topics to be addressed
37 in the report shall include the number of participants in the pilot
38 program, the number of participants in the pilot program who were
39 issued physician's and surgeon's certificates by the board, the
40 number of participants who practice in designated medically

underserved areas, and the potential for retention or expansion of the pilot program.

(f) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

~~SEC. 29.~~

SEC. 28. Section 2067 of the Business and Professions Code is repealed.

~~SEC. 30.~~

SEC. 29. Section 2072 of the Business and Professions Code is repealed.

~~SEC. 31.~~

SEC. 30. Section 2073 of the Business and Professions Code is repealed.

~~SEC. 32.~~

SEC. 31. Section 2082 of the Business and Professions Code is amended to read:

2082. Each application shall include the following:

(a) A diploma issued by an approved medical school. The requirements of the school shall have been at the time of granting the diploma in no degree less than those required under this chapter or by any preceding medical practice act at the time that the diploma was granted. In lieu of a diploma, the applicant may submit evidence satisfactory to the board of having possessed the same.

(b) An official transcript or other official evidence satisfactory to the board showing each approved medical school in which a resident course of professional instruction was pursued covering the minimum requirements for certification as a physician and surgeon, and that a diploma and degree were granted by the school.

(c) Other information concerning the professional instruction and preliminary education of the applicant as the board may require.

(d) Proof of passage of the written examinations as provided under Article 9 (commencing with Section 2170) with a score acceptable to the board.

(e) Proof of satisfactory completion of the postgraduate training required under Section 2096 on a form approved by the board.

(f) An affidavit showing to the satisfaction of the board that the applicant is the person named in each diploma and transcript that

1 he or she submits, that he or she is the lawful holder thereof, and
2 that the diploma or transcript was procured in the regular course
3 of professional instruction and examination without fraud or
4 misrepresentation.

5 (g) Either fingerprint cards or a copy of a completed Live Scan
6 form from the applicant in order to establish the identity of the
7 applicant and in order to determine whether the applicant has a
8 record of any criminal convictions in this state or in any other
9 jurisdiction, including foreign countries. The information obtained
10 as a result of the fingerprinting of the applicant shall be used in
11 accordance with Section 11105 of the Penal Code, and to determine
12 whether the applicant is subject to denial of licensure under the
13 provisions of Division 1.5 (commencing with Section 475) and
14 Section 2221.

15 (h) If the applicant attended a foreign medical school approved
16 by the board pursuant to Section 2084, an official Educational
17 Commission for Foreign Medical Graduates (ECFMG)
18 Certification Status Report submitted by the Educational
19 Commission for Foreign Medical Graduates confirming the
20 graduate is ECFMG certified.

21 (i) If the applicant attended a foreign medical school approved
22 by the board pursuant to Section 2084, official evidence satisfactory
23 to the board of completion of all formal requirements of the
24 medical school for graduation, except the applicant shall not be
25 required to have completed an internship or social service or be
26 admitted or licensed to practice medicine in the country in which
27 the professional instruction was completed.

28 ~~SEC. 33.~~

29 *SEC. 32.* Section 2084 of the Business and Professions Code
30 is amended to read:

31 2084. (a) Medical schools accredited by a national accrediting
32 agency approved by the board and recognized by the United States
33 Department of Education shall be deemed approved by the board.

34 (b) The board shall determine a foreign medical school to be a
35 recognized medical school if the foreign medical school meets any
36 of the following requirements:

37 (1) The foreign medical school has been evaluated by the
38 Educational Commission for Foreign Medical Graduates (ECFMG)
39 or one of the ECFMG authorized foreign medical school
40 accreditation agencies and deemed to meet the minimum

1 requirements substantially equivalent to the requirements of
2 medical schools accredited by the Liaison Committee on Medical
3 Education, the Committee on Accreditation of Canadian Medical
4 Schools, or the Commission on Osteopathic College Accreditation.

5 (2) The foreign medical school is listed on the World Federation
6 for Medical Education (WFME) and the Foundation for
7 Advancement of International Medical Education and Research
8 (FAIMER) World Directory of Medical Schools joint directory or
9 the World Directory of Medical Schools.

10 (3) The foreign medical school had been previously approved
11 by the board. The prior approval shall only be valid for a maximum
12 of seven years from the date of enactment of this section.

13 ~~SEC. 34.~~

14 *SEC. 33.* Section 2084.5 of the Business and Professions Code
15 is amended to read:

16 2084.5. Notwithstanding any other law, a medical school or
17 medical school program accredited by the Liaison Committee on
18 Medical Education, the Committee on Accreditation of Canadian
19 Medical Schools, or the Commission on Osteopathic College
20 Accreditation shall be deemed to meet the requirements of Section
21 2084.

22 ~~SEC. 35.~~

23 *SEC. 34.* Section 2085 of the Business and Professions Code
24 is repealed.

25 ~~SEC. 36.~~

26 *SEC. 35.* Section 2087 of the Business and Professions Code
27 is amended to read:

28 2087. If any applicant for licensure is rejected by the board,
29 then the applicant may commence an action in the superior court
30 as provided in Section 2019 against the board to compel it to issue
31 the applicant a certificate or for any other appropriate relief. If the
32 applicant is denied a certificate on the grounds of unprofessional
33 conduct, the provisions of Article 12 (commencing with Section
34 2220) shall apply. In such an action the court shall proceed under
35 Section 1094.5 of the Code of Civil Procedure, except that the
36 court may not exercise an independent judgment on the evidence.
37 The action shall be speedily determined by the court and shall take
38 precedence over all matters pending therein except criminal cases,
39 applications for injunction, or other matters to which special
40 precedence may be given by law.

1 ~~SEC. 37.~~
2 ~~SEC. 36.~~ Section 2089 of the Business and Professions Code
3 is repealed.
4 ~~SEC. 38.~~
5 ~~SEC. 37.~~ Section 2089.5 of the Business and Professions Code
6 is repealed.
7 ~~SEC. 39.~~
8 ~~SEC. 38.~~ Section 2089.7 of the Business and Professions Code
9 is repealed.
10 ~~SEC. 40.~~
11 ~~SEC. 39.~~ Section 2090 of the Business and Professions Code
12 is repealed.
13 ~~SEC. 41.~~
14 ~~SEC. 40.~~ Section 2091 of the Business and Professions Code
15 is repealed.
16 ~~SEC. 42.~~
17 ~~SEC. 41.~~ Section 2091.1 of the Business and Professions Code
18 is repealed.
19 ~~SEC. 43.~~
20 ~~SEC. 42.~~ Section 2091.2 of the Business and Professions Code
21 is repealed.
22 ~~SEC. 44.~~
23 ~~SEC. 43.~~ Section 2096 of the Business and Professions Code
24 is amended to read:
25 2096. (a) In addition to other requirements of this chapter,
26 before a physician's and surgeon's license may be issued, each
27 applicant, including an applicant applying pursuant to Article 5
28 (commencing with Section 2100), shall show by evidence
29 satisfactory to the board that he or she has satisfactorily completed
30 at least 36 months of board-approved postgraduate training.
31 (b) The postgraduate training required by this section shall
32 include at least four months of general medicine and shall be
33 obtained in a postgraduate training program approved by the
34 Accreditation Council for Graduate Medical Education (ACGME),
35 the Royal College of Physicians and Surgeons of Canada (RCPSC),
36 or the College of Family Physicians of Canada (CFPC).
37 (c) An applicant who has completed at least 36 months of
38 board-approved postgraduate training, not less than 24 months of
39 which was completed as a resident after receiving a medical degree
40 from a combined dental and medical degree program accredited

1 by the Commission on Dental Accreditation (CODA) or approved
2 by the board, shall be eligible for licensure.

3 ~~SEC. 45.~~

4 ~~SEC. 44.~~ Section 2100 of the Business and Professions Code
5 is repealed.

6 ~~SEC. 46.~~

7 ~~SEC. 45.~~ Section 2102 of the Business and Professions Code
8 is repealed.

9 ~~SEC. 47.~~

10 ~~SEC. 46.~~ Section 2103 of the Business and Professions Code
11 is repealed.

12 ~~SEC. 48.~~

13 ~~SEC. 47.~~ Section 2104 of the Business and Professions Code
14 is repealed.

15 ~~SEC. 49.~~

16 ~~SEC. 48.~~ Section 2104.5 of the Business and Professions Code
17 is repealed.

18 ~~SEC. 50.~~

19 ~~SEC. 49.~~ Section 2105 of the Business and Professions Code
20 is amended to read:

21 2105. No hospital licensed by this state, or operated by the
22 state or a political subdivision thereof, or which receives state
23 financial assistance, directly or indirectly, shall require an
24 individual who at the time of his or her enrollment in a medical
25 school outside the United States is a citizen of the United States,
26 to satisfy any requirements other than those contained in paragraph
27 (3) of subdivision (a) of Section 2065 prior to commencing the
28 postgraduate training which are not required for graduates of
29 approved medical schools located in the United States or Canada.

30 ~~SEC. 51.~~

31 ~~SEC. 50.~~ Section 2107 of the Business and Professions Code
32 is repealed.

33 ~~SEC. 52.~~

34 ~~SEC. 51.~~ Section 2111 of the Business and Professions Code
35 is amended to read:

36 2111. (a) Physicians who are not citizens but who meet the
37 requirements of subdivision (b) and who seek postgraduate study
38 in an approved medical school may, after receipt of an appointment
39 from the dean of the California medical school and application to
40 and approval by the board, be permitted to participate in the

1 professional activities of the department or division in the medical
2 school to which they are appointed. The physician shall be under
3 the direction of the head of the department to which he or she is
4 appointed, supervised by the staff of the medical school's medical
5 center, and known for these purposes as a "visiting fellow." The
6 visiting fellow shall wear a visible name tag containing the title
7 "visiting fellow" when he or she provides clinical services.

8 (b) (1) Application for approval shall be made on a form
9 prescribed by the division and shall be accompanied by a fee fixed
10 by the board in an amount necessary to recover the actual
11 application processing costs of the program. The application shall
12 show that the person does not immediately qualify for a physician's
13 and surgeon's certificate under this chapter and that the person has
14 completed at least three years of postgraduate basic residency
15 requirements. The application shall include a written statement of
16 the recruitment procedures followed by the medical school before
17 offering the appointment to the applicant.

18 (2) Approval shall be granted only for appointment to one
19 medical school, and no physician shall be granted more than one
20 approval for the same period of time.

21 (3) Approval may be granted for a maximum of three years and
22 shall be renewed annually. The medical school shall submit a
23 request for renewal on a form prescribed by the board, which shall
24 be accompanied by a renewal fee fixed by the board in an amount
25 necessary to recover the actual application processing costs of the
26 program.

27 (c) Except to the extent authorized by this section, the visiting
28 fellow may not engage in the practice of medicine. Neither the
29 visiting fellow nor the medical school may assess any charge for
30 the medical services provided by the visiting fellow, and the
31 visiting fellow may not receive any other compensation therefor.

32 (d) The time spent under appointment in a medical school
33 pursuant to this section may not be used to meet the requirements
34 for licensure.

35 (e) The board shall notify both the visiting fellow and the dean
36 of the appointing medical school of any complaint made about the
37 visiting fellow.

38 The board may terminate its approval of an appointment for any
39 act that would be grounds for discipline if done by a licensee. The
40 board shall provide both the visiting fellow and the dean of the

1 medical school with a written notice of termination including the
2 basis for that termination. The visiting fellow may, within 30 days
3 after the date of the notice of termination, file a written appeal to
4 the board. The appeal shall include any documentation the visiting
5 fellow wishes to present to the board.

6 (f) Nothing in this section shall preclude any United States
7 citizen who has received his or her medical degree from a medical
8 school located in a foreign country and recognized by the board
9 from participating in any program established pursuant to this
10 section.

11 ~~SEC. 53.~~

12 *SEC. 52.* Section 2112 of the Business and Professions Code
13 is amended to read:

14 2112. (a) Physicians who are not citizens and who seek
15 postgraduate study, may, after application to and approval by the
16 board, be permitted to participate in a fellowship program in a
17 specialty or subspecialty field, providing the fellowship program
18 is given in a hospital in this state which is approved by the Joint
19 Commission and providing the service is satisfactory to the board.
20 Such physicians shall at all times be under the direction and
21 supervision of a licensed, board-certified physician and surgeon
22 who is recognized as a clearly outstanding specialist in the field
23 in which the foreign fellow is to be trained. The supervisor, as part
24 of the application process, shall submit his or her curriculum vitae
25 and a protocol of the fellowship program to be completed by the
26 foreign fellow. Approval of the program and supervisor is for a
27 period of one year, but may be renewed annually upon application
28 to and approval by the board. The approval may not be renewed
29 more than four times. The board may determine a fee, based on
30 the cost of operating this program, which shall be paid by the
31 applicant at the time the application is filed.

32 (b) Except to the extent authorized by this section, no such
33 visiting physician may engage in the practice of medicine or receive
34 compensation therefor. The time spent under appointment in a
35 medical school pursuant to this section may not be used to meet
36 the requirements for licensure.

37 (c) Nothing in this section shall preclude any United States
38 citizen who has received his or her medical degree from a medical
39 school located in a foreign country from participating in any
40 program established pursuant to this section.

1 ~~SEC. 54.~~

2 *SEC. 53.* Section 2113 of the Business and Professions Code
3 is amended to read:

4 2113. (a) Any person who does not immediately qualify for
5 a physician's and surgeon's certificate under this chapter and who
6 is offered by the dean of an approved medical school in this state
7 a full-time faculty position may, after application to and approval
8 by the board, be granted a certificate of registration to engage in
9 the practice of medicine only to the extent that the practice is
10 incident to and a necessary part of his or her duties as approved
11 by the board in connection with the faculty position. A certificate
12 of registration does not authorize a registrant to admit patients to
13 a nursing or a skilled or assisted living facility unless that facility
14 is formally affiliated with the sponsoring medical school. A clinical
15 fellowship shall not be submitted as a faculty service appointment.

16 (b) Application for a certificate of registration shall be made on
17 a form prescribed by the board and shall be accompanied by a
18 registration fee fixed by the board in an amount necessary to
19 recover the actual application processing costs of the program. To
20 qualify for the certificate, an applicant shall submit all of the
21 following:

22 (1) If the applicant is a graduate of a medical school other than
23 in the United States or Canada, documentary evidence satisfactory
24 to the board that he or she has been licensed to practice medicine
25 and surgery for not less than four years in another state or country
26 whose requirements for licensure are satisfactory to the board, or
27 has been engaged in the practice of medicine in the United States
28 for at least four years in approved facilities, or has completed a
29 combination of that licensure and training.

30 (2) If the applicant is a graduate of a medical school in the
31 United States or Canada, documentary evidence that the medical
32 school is approved by the board.

33 (3) Written certification by the head of the department in which
34 the applicant is to be appointed of all of the following:

35 (A) The applicant will be under his or her direction.

36 (B) The applicant will not be permitted to practice medicine
37 unless incident to and a necessary part of his or her duties as
38 approved by the board in subdivision (a).

1 (C) The applicant will be accountable to the medical school's
2 department chair or division chief for the specialty in which the
3 applicant will practice.

4 (D) The applicant will be proctored in the same manner as other
5 new faculty members, including, as appropriate, review by the
6 medical staff of the school's medical center.

7 (E) The applicant will not be appointed to a supervisory position
8 at the level of a medical school department chair or division chief.

9 (4) Demonstration by the dean of the medical school that the
10 applicant has the requisite qualifications to assume the position to
11 which he or she is to be appointed and that shall include a written
12 statement of the recruitment procedures followed by the medical
13 school before offering the faculty position to the applicant.

14 (c) A certificate of registration shall be issued only for a faculty
15 position at one approved medical school, and no person shall be
16 issued more than one certificate of registration for the same period
17 of time.

18 (d) (1) A certificate of registration is valid for one year from
19 its date of issuance and may be renewed twice.

20 A request for renewal shall be submitted on a form prescribed
21 by the board and shall be accompanied by a renewal fee fixed by
22 the board in an amount necessary to recover the actual application
23 processing costs of the program.

24 (2) The dean of the medical school may request renewal of the
25 registration by submitting a plan at the beginning of the third year
26 of the registrant's appointment demonstrating the registrant's
27 continued progress toward licensure and, if the registrant is a
28 graduate of a medical school other than in the United States or
29 Canada, that the registrant has been issued a certificate by the
30 Educational Commission for Foreign Medical Graduates. The
31 board may, in its discretion, extend the registration for a two-year
32 period to facilitate the registrant's completion of the licensure
33 process.

34 (e) If the registrant is a graduate of a medical school other than
35 in the United States or Canada, he or she shall meet the
36 requirements of Section 2065 or 2135, as appropriate, in order to
37 obtain a physician's and surgeon's certificate. Notwithstanding
38 any other provision of law, the board may, in its discretion, waive
39 the examination and the Educational Commission for Foreign
40 Medical Graduates certification requirements specified in paragraph

(3) of subdivision (a) of Section 2065 in the event the registrant applies for a physician's and surgeon's certificate. As a condition to waiving any examination or the Educational Commission for Foreign Medical Graduates certification requirement, the board in its discretion, may require an applicant to pass a clinical competency examination approved by the board. The board shall not waive any examination for an applicant who has not completed at least one year in the faculty position.

(f) Except to the extent authorized by this section, the registrant shall not engage in the practice of medicine, bill individually for medical services provided by the registrant, or receive compensation therefor, unless he or she is issued a physician's and surgeon's certificate.

(g) When providing clinical services, the registrant shall wear a visible name tag containing the title "visiting professor" or "visiting faculty member," as appropriate, and the institution at which the services are provided shall obtain a signed statement from each patient to whom the registrant provides services acknowledging that the patient understands that the services are provided by a person who does not hold a physician's and surgeon's certificate but who is qualified to participate in a special program as a visiting professor or faculty member.

(h) The board shall notify both the registrant and the dean of the medical school of a complaint made about the registrant. The board may terminate a registration for any act that would be grounds for discipline if done by a licensee. The board shall provide both the registrant and the dean of the medical school with written notice of the termination and the basis for that termination. The registrant may, within 30 days after the date of the notice of termination, file a written appeal to the board. The appeal shall include any documentation the registrant wishes to present to the board.

~~SEC. 55.~~

SEC. 54. Section 2115 of the Business and Professions Code is repealed.

~~SEC. 56.~~

SEC. 55. Section 2135 of the Business and Professions Code is amended to read:

1 2135. The board shall issue a physician and surgeon's
2 certificate to an applicant who meets all of the following
3 requirements:

4 (a) The applicant holds an unlimited license as a physician and
5 surgeon in another state or states, or in a Canadian province or
6 Canadian provinces, which was issued upon:

7 (1) Successful completion of a resident course of professional
8 instruction leading to a degree of medical doctor from a
9 board-approved medical school pursuant to Section 2084.

10 (2) Taking and passing a written examination that is recognized
11 by the board to be equivalent in content to that administered in
12 California.

13 (b) The applicant has held an unrestricted license to practice
14 medicine, in a state or states, in a Canadian province or Canadian
15 provinces, or as a member of the active military, United States
16 Public Health Services, or other federal program, for a period of
17 at least four years. Any time spent by the applicant in an approved
18 postgraduate training program or clinical fellowship acceptable to
19 the board shall not be included in the calculation of this four-year
20 period.

21 (c) The board determines that no disciplinary action has been
22 taken against the applicant by any medical licensing authority and
23 that the applicant has not been the subject of adverse judgments
24 or settlements resulting from the practice of medicine that the
25 board determines constitutes evidence of a pattern of negligence
26 or incompetence.

27 (d) The applicant has satisfactorily completed at least one year
28 of approved postgraduate training and is certified by a specialty
29 board approved by the American Board of Medical Specialties or
30 approved by the board pursuant to subdivision (h) of Section 651.

31 (e) The applicant has not committed any acts or crimes
32 constituting grounds for denial of a certificate under Division 1.5
33 (commencing with Section 475) or Article 12 (commencing with
34 Section 2220).

35 (f) Any application received from an applicant who has held an
36 unrestricted license to practice medicine, in a state or states, or
37 Canadian province or Canadian provinces, or as a member of the
38 active military, United States Public Health Services, or other
39 federal program for four or more years shall be reviewed and
40 processed pursuant to this section. Any time spent by the applicant

1 in an approved postgraduate training program or clinical fellowship
2 acceptable to the board shall not be included in the calculation of
3 this four-year period. This subdivision does not apply to
4 applications that may be reviewed and processed pursuant to
5 Section 2151.

6 ~~SEC. 57.~~

7 *SEC. 56.* Section 2135.5 of the Business and Professions Code
8 is amended to read:

9 2135.5. Upon review and recommendation, the board may
10 determine that an applicant for a physician's and surgeon's
11 certificate has satisfied the medical education requirements of
12 Sections 2135 and 2084 and the examination requirements of
13 Section 2170 if the applicant meets all of the following criteria:

14 (a) He or she holds an unlimited and unrestricted license as a
15 physician and surgeon in another state and has held that license
16 continuously for a minimum of four years prior to the date of
17 application.

18 (b) He or she is certified by a specialty board that is a member
19 board of the American Board of Medical Specialties.

20 (c) He or she is not subject to denial of licensure under Division
21 1.5 (commencing with Section 475) or Article 12 (commencing
22 with Section 2220).

23 (d) He or she has not been the subject of a disciplinary action
24 by a medical licensing authority or of an adverse judgment or
25 settlement resulting from the practice of medicine that, as
26 determined by the board, constitutes a pattern of negligence or
27 incompetence.

28 ~~SEC. 58.~~

29 *SEC. 57.* Section 2135.7 of the Business and Professions Code
30 is repealed.

31 ~~SEC. 59.~~

32 *SEC. 58.* Section 2143 of the Business and Professions Code
33 is amended to read:

34 2143. An applicant for a reciprocity certificate need not have
35 completed the postgraduate training required in Section 2096 prior
36 to the issuance of a license in another state, if the applicant
37 complies with the requirements of Section 2096 before application
38 is made to the board for a reciprocity certificate.

~~SEC. 60.~~

SEC. 59. Section 2168.4 of the Business and Professions Code is amended to read:

2168.4. (a) A special faculty permit expires and becomes invalid at midnight on the last day of the month in which the permit was issued during the second year of a two-year term commencing from the date of issuance, if not renewed.

(b) A person who holds a special faculty permit shall show at the time of license renewal that he or she continues to meet the eligibility criteria set forth in Section 2168.1. After the first renewal of a special faculty permit, the permitholder shall not be required to hold a full-time faculty position, and may instead be employed part-time in a position that otherwise meets the requirements set forth in paragraph (1) of subdivision (a) of Section 2168.1.

(c) A person who holds a special faculty permit shall show at the time of license renewal that he or she meets the continuing medical education requirements of Article 10 (commencing with Section 2190).

(d) In addition to the requirements set forth above, a special faculty permit shall be renewed in accordance with Article 19 (commencing with Section 2420) in the same manner as a physician's and surgeon's certificate.

(e) Those fees applicable to a physician's and surgeon's certificate shall also apply to a special faculty permit and shall be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California.

~~SEC. 61.~~

SEC. 60. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human sexuality, defined as the study of a human being as a sexual being and how he or she functions with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The board shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

1 (c) The board shall consider including a course in acupuncture
2 to be taken by those licensees whose practices may require
3 knowledge in the area of acupuncture and whose education has
4 not included instruction in acupuncture.

5 (d) The board shall encourage every physician and surgeon to
6 take nutrition as part of his or her continuing education, particularly
7 a physician and surgeon involved in primary care.

8 (e) The board shall consider including a course in elder abuse
9 detection and treatment to be taken by those licensees whose
10 practices are of a nature that there is a likelihood of contact with
11 abused or neglected persons 65 years of age and older.

12 (f) In determining its continuing education requirements, the
13 board shall consider including a course in the early detection and
14 treatment of substance abusing pregnant women to be taken by
15 those licensees whose practices are of a nature that there is a
16 likelihood of contact with these women.

17 (g) In determining its continuing education requirements, the
18 board shall consider including a course in the special care needs
19 of drug addicted infants to be taken by those licensees whose
20 practices are of a nature that there is a likelihood of contact with
21 these infants.

22 (h) In determining its continuing education requirements, the
23 board shall consider including a course providing training and
24 guidelines on how to routinely screen for signs exhibited by abused
25 women, particularly for physicians and surgeons in emergency,
26 surgical, primary care, pediatric, prenatal, and mental health
27 settings. In the event the board establishes a requirement for
28 continuing education coursework in spousal or partner abuse
29 detection or treatment, that requirement shall be met by each
30 licensee within no more than four years from the date the
31 requirement is imposed.

32 (i) In determining its continuing education requirements, the
33 board shall consider including a course in the special care needs
34 of individuals and their families facing end-of-life issues, including,
35 but not limited to, all of the following:

- 36 (1) Pain and symptom management.
- 37 (2) The psycho-social dynamics of death.
- 38 (3) Dying and bereavement.
- 39 (4) Hospice care.

1 (j) In determining its continuing education requirements, the
2 board shall give its highest priority to considering a course on pain
3 management.

4 (k) In determining its continuing education requirements, the
5 board shall consider including a course in geriatric care for
6 emergency room physicians and surgeons.

7 ~~SEC. 62.~~

8 *SEC. 61.* Section 2216.3 of the Business and Professions Code
9 is amended to read:

10 2216.3. (a) An outpatient setting accredited pursuant to Section
11 1248.1 of the Health and Safety Code shall report an adverse event
12 to the board no later than five days after the adverse event has been
13 detected, or, if that event is an ongoing urgent or emergent threat
14 to the welfare, health, or safety of patients, personnel, or visitors,
15 not later than 24 hours after the adverse event has been detected.
16 Disclosure of individually identifiable patient information shall
17 be consistent with applicable law.

18 (b) For the purposes of this section, “adverse event” includes
19 any of the following:

20 (1) Surgical or other invasive procedures, including the
21 following:

22 (A) Surgical or other invasive procedure performed on a wrong
23 body part that is inconsistent with the documented informed
24 consent for that patient. A reportable event under this subparagraph
25 does not include a situation requiring prompt action that occurs in
26 the course of surgery or a situation that is so urgent as to preclude
27 obtaining informed consent.

28 (B) Surgical or other invasive procedure performed on the wrong
29 patient.

30 (C) The wrong surgical or other invasive procedure performed
31 on a patient, which is a procedure performed on a patient that is
32 inconsistent with the documented informed consent for that patient.
33 A reportable event under this subparagraph does not include a
34 situation requiring prompt action that occurs in the course of
35 surgery, or a situation that is so urgent as to preclude the obtaining
36 of informed consent.

37 (D) Retention of a foreign object in a patient after surgery or
38 other procedure, excluding objects intentionally implanted as part
39 of a planned intervention and objects present prior to surgery that
40 are intentionally retained.

1 (E) Death of a patient during or up to 24 hours after admittance
2 of a patient to an outpatient setting that follows induction of
3 anesthesia after surgery of a normal, healthy patient who has no
4 organic, physiologic, biochemical, or psychiatric disturbance and
5 for whom the pathologic processes for which the operation is to
6 be performed are localized and do not entail a systemic disturbance.

7 (F) Transfer of a patient to a hospital or emergency center for
8 medical treatment for a period exceeding 24 hours following a
9 scheduled procedure outside of a general acute care hospital, as
10 defined in subdivision (a) of Section 1250 of the Health and Safety
11 Code.

12 (2) Product or device events, including the following:

13 (A) Patient death or serious disability associated with the use
14 of a contaminated drug, device, or biologic provided by the
15 outpatient setting when the contamination is the result of generally
16 detectable contaminants in the drug, device, or biologic, regardless
17 of the source of the contamination or the product.

18 (B) Patient death or serious disability associated with the use
19 or function of a device in patient care in which the device is used
20 or functions other than as intended. For purposes of this
21 subparagraph, “device” includes, but is not limited to, a catheter,
22 drain, or other specialized tube, infusion pump, or ventilator.

23 (C) Patient death or serious disability associated with
24 intravascular air embolism that occurs while being cared for in an
25 outpatient setting, excluding deaths associated with neurosurgical
26 procedures known to present a high risk of intravascular air
27 embolism.

28 (3) Patient protection events, including the following:

29 (A) A minor discharged to the wrong person.

30 (B) A patient suicide or attempted suicide resulting in serious
31 disability while being cared for in an outpatient setting due to
32 patient actions after admission to the outpatient setting.

33 (4) Care management events, including the following:

34 (A) A patient death or serious disability associated with a
35 medication error, including, but not limited to, an error involving
36 the wrong drug, the wrong dose, the wrong patient, the wrong
37 time, the wrong rate, the wrong preparation, or the wrong route of
38 administration, excluding reasonable differences in clinical
39 judgment on drug selection and dose.

1 (B) A patient death or serious disability associated with a
2 hemolytic reaction due to the administration of ABO-incompatible
3 blood or blood products.

4 (C) Patient death or serious disability directly related to
5 hypoglycemia, the onset of which occurs while the patient is being
6 cared for in an outpatient setting.

7 (D) A patient death or serious disability due to spinal
8 manipulative therapy performed at the outpatient setting.

9 (5) Environmental events, including the following:

10 (A) A patient death or serious disability associated with an
11 electric shock while being cared for in an outpatient setting,
12 excluding events involving planned treatments, such as electric
13 countershock.

14 (B) Any incident in which a line designated for oxygen or other
15 gas to be delivered to a patient contains the wrong gas or is
16 contaminated by a toxic substance.

17 (C) A patient death or serious disability associated with a burn
18 incurred from any source while being cared for in an outpatient
19 setting.

20 (D) A patient death associated with a fall while being cared for
21 in an outpatient setting.

22 (E) A patient death or serious disability associated with the use
23 of restraints or bed rails while being cared for in an outpatient
24 setting.

25 (6) Criminal events, including the following:

26 (A) Any instance of care ordered by or provided by someone
27 impersonating a physician, nurse, pharmacist, or other licensed
28 health care provider.

29 (B) The abduction of a patient of any age.

30 (C) The sexual assault on a patient within or on the grounds of
31 an outpatient setting.

32 (D) The death or significant injury of a patient or staff member
33 resulting from a physical assault that occurs within or on the
34 grounds of an outpatient setting.

35 (7) An adverse event or series of adverse events that cause the
36 death or serious disability of a patient, personnel, or visitor.

37 (c) The outpatient setting shall inform the patient or the party
38 responsible for the patient of the adverse event by the time the
39 report is made.

(d) “Serious disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

(e) “Surgical or other invasive procedures” are defined for the purposes of this section as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology.

~~SEC. 63.~~

SEC. 62. Section 2216.5 is added to the Business and Professions Code, to read:

2216.5. (a) An outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall, on or before February 15 of each year, file with the Office of Statewide Health Planning and Development upon forms to be furnished by the office, or through an approved benchmarking provider, a verified report showing the following information relating to the previous calendar year:

(1) Number of patients served and descriptive information, including age, gender, race, and ethnic background of patients.

(2) Number of patient visits by type of service.

(3) Number of hospital transfers and admissions upon discharge from an outpatient setting.

(4) Number of patient falls within the outpatient setting.

(5) Number of patient burns prior to discharge from an outpatient setting.

(6) Number of patients who experience a wrong site, side, patient, procedure, or implant.

(7) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(8) Death of a patient within 24 hours after admittance of a patient to an outpatient setting.

(b) It is the expressed intent of the Legislature that the patient’s rights of confidentiality shall not be violated in any manner. Patient

1 social security numbers and any other data elements that the office
2 believes could be used to determine the identity of an individual
3 patient shall be exempt from the disclosure requirements of the
4 California Public Records Act (Chapter 3.5 (commencing with
5 Section 6250) of Division 7 of Title 1 of the Government Code).

6 (c) No person reporting data pursuant to this section shall be
7 liable for damages in any action based on the use or misuse of
8 patient-identifiable data that has been mailed or otherwise
9 transmitted to the office pursuant to the requirements of this
10 section.

11 ~~SEC. 64.~~

12 *SEC. 63.* Section 2220.05 of the Business and Professions Code
13 is amended to read:

14 2220.05. (a) In order to ensure that its resources are maximized
15 for the protection of the public, the Medical Board of California
16 and the California Board of Podiatric Medicine shall prioritize
17 their investigative and prosecutorial resources to ensure that
18 physicians and surgeons and doctors of podiatric medicine
19 representing the greatest threat of harm are identified and
20 disciplined expeditiously. Cases involving any of the following
21 allegations shall be handled on a priority basis, as follows, with
22 the highest priority being given to cases in the first paragraph:

23 (1) Gross negligence, incompetence, or repeated negligent acts
24 that involve death or serious bodily injury to one or more patients,
25 such that the physician and surgeon or the doctor of podiatric
26 medicine represents a danger to the public.

27 (2) Drug or alcohol abuse by a physician and surgeon or a doctor
28 of podiatric medicine involving death or serious bodily injury to
29 a patient.

30 (3) Repeated acts of clearly excessive prescribing, furnishing,
31 or administering of controlled substances, or repeated acts of
32 prescribing, dispensing, or furnishing of controlled substances
33 without a good faith prior examination of the patient and medical
34 reason therefor. However, in no event shall a physician and surgeon
35 prescribing, furnishing, or administering controlled substances for
36 intractable pain consistent with lawful prescribing, including, but
37 not limited to, Sections 725, 2241.5, and 2241.6 of this code and
38 Sections 11159.2 and 124961 of the Health and Safety Code, be
39 prosecuted for excessive prescribing and prompt review of the

1 applicability of these provisions shall be made in any complaint
2 that may implicate these provisions.

3 (4) Repeated acts of clearly excessive recommending of cannabis
4 to patients for medical purposes, or repeated acts of recommending
5 cannabis to patients for medical purposes without a good faith
6 prior examination of the patient and a medical reason for the
7 recommendation.

8 (5) Sexual misconduct with one or more patients during a course
9 of treatment or an examination.

10 (6) Practicing medicine while under the influence of drugs or
11 alcohol.

12 (7) Repeated acts of clearly excessive prescribing, furnishing,
13 or administering psychotropic medications to a minor without a
14 good faith prior examination of the patient and medical reason
15 therefor.

16 (b) The board may by regulation prioritize cases involving an
17 allegation of conduct that is not described in subdivision (a). Those
18 cases prioritized by regulation shall not be assigned a priority equal
19 to or higher than the priorities established in subdivision (a).

20 (c) The Medical Board of California shall indicate in its annual
21 report mandated by Section 2312 the number of temporary
22 restraining orders, interim suspension orders, and disciplinary
23 actions that are taken in each priority category specified in
24 subdivisions (a) and (b).

25 ~~SEC. 65.~~

26 *SEC. 64.* Section 2221 of the Business and Professions Code
27 is amended to read:

28 2221. (a) The board may deny a physician's and surgeon's
29 certificate to an applicant guilty of unprofessional conduct or of
30 any cause that would subject a licensee to revocation or suspension
31 of his or her license. The board in its sole discretion, may issue a
32 probationary physician's and surgeon's certificate to an applicant
33 subject to terms and conditions, including, but not limited to, any
34 of the following conditions of probation:

35 (1) Practice limited to a supervised, structured environment
36 where the licensee's activities shall be supervised by another
37 physician and surgeon.

38 (2) Total or partial restrictions on drug prescribing privileges
39 for controlled substances.

40 (3) Continuing medical or psychiatric treatment.

1 (4) Ongoing participation in a specified rehabilitation program.

2 (5) Enrollment and successful completion of a clinical training
3 program.

4 (6) Abstention from the use of alcohol or drugs.

5 (7) Restrictions against engaging in certain types of medical
6 practice.

7 (8) Compliance with all provisions of this chapter.

8 (9) Payment of the cost of probation monitoring.

9 (b) The board may modify or terminate the terms and conditions
10 imposed on the probationary certificate upon receipt of a petition
11 from the licensee; however, the requirements of Section 2228.1
12 are mandatory with any probationary licensee. The board may
13 assign the petition to an administrative law judge designated in
14 Section 11371 of the Government Code. After a hearing on the
15 petition, the administrative law judge shall provide a proposed
16 decision to the board.

17 (c) The board shall deny a physician's and surgeon's certificate
18 to an applicant who is required to register pursuant to Section 290
19 of the Penal Code. This subdivision does not apply to an applicant
20 who is required to register as a sex offender pursuant to Section
21 290 of the Penal Code solely because of a misdemeanor conviction
22 under Section 314 of the Penal Code.

23 (d) An applicant shall not be eligible to reapply for a physician's
24 and surgeon's certificate for a minimum of three years from the
25 effective date of the denial of his or her application, except that
26 the board may, in its discretion and for good cause demonstrated,
27 permit reapplication after not less than one year has elapsed from
28 the effective date of the denial.

29 ~~SEC. 66.~~

30 *SEC. 65.* Section 2225 of the Business and Professions Code
31 is amended to read:

32 2225. (a) Notwithstanding Section 2263 and any other law,
33 including laws pertaining to the psychotherapist-patient privilege,
34 making a communication between a physician and surgeon or a
35 doctor of podiatric medicine and his or her patients a privileged
36 communication, those provisions shall not apply to investigations
37 or proceedings conducted under this chapter. Members of the
38 board, the Senior Assistant Attorney General of the Health Quality
39 Enforcement Section, members of the California Board of Podiatric
40 Medicine, and deputies, employees, agents, and representatives of

1 the board or the California Board of Podiatric Medicine and the
2 Senior Assistant Attorney General of the Health Quality
3 Enforcement Section shall keep in confidence during the course
4 of investigations, the names of any patients whose records are
5 reviewed and shall not disclose or reveal those names, except as
6 is necessary during the course of an investigation, unless and until
7 proceedings are instituted. The authority of the board or the
8 California Board of Podiatric Medicine and the Health Quality
9 Enforcement Section to examine records of patients in the office
10 of a physician and surgeon or a doctor of podiatric medicine is
11 limited to records of patients who have complained to the board
12 or the California Board of Podiatric Medicine about that licensee.

13 (b) Notwithstanding any other law, the Attorney General and
14 his or her investigative agents, and investigators and representatives
15 of the board or the California Board of Podiatric Medicine, may
16 inquire into any alleged violation of the Medical Practice Act or
17 any other federal or state law, regulation, or rule relevant to the
18 practice of medicine or podiatric medicine, whichever is applicable,
19 and may inspect documents relevant to those investigations in
20 accordance with the following procedures:

21 (1) Any document relevant to an investigation may be inspected,
22 and copies may be obtained, where patient consent is given.

23 (2) Any document relevant to the business operations of a
24 licensee, and not involving medical records attributable to
25 identifiable patients, may be inspected and copied if relevant to
26 an investigation of a licensee.

27 (c) (1) Notwithstanding subdivision (b) or any other law, in
28 any investigation that involves the death of a patient, the board
29 may inspect and copy the medical records of the deceased patient
30 without the authorization of the beneficiary or personal
31 representative of the deceased patient or a court order solely for
32 the purpose of determining the extent to which the death was the
33 result of the physician and surgeon's conduct in violation of the
34 Medical Practice Act, if the board provides a written request to
35 either the physician and surgeon or the facility where the medical
36 records are located or the care to the deceased patient was provided,
37 that includes a declaration that the board has been unsuccessful in
38 locating or contacting the deceased patient's beneficiary or personal
39 representative after reasonable efforts. Nothing in this subdivision
40 shall be construed to allow the board to inspect and copy the

1 medical records of a deceased patient without a court order when
2 the beneficiary or personal representative of the deceased patient
3 has been located and contacted but has refused to consent to the
4 board inspecting and copying the medical records of the deceased
5 patient.

6 (2) The Legislature finds and declares that the authority created
7 in the board pursuant to this section, and a physician and surgeon's
8 compliance with this section, are consistent with the public interest
9 and benefit activities of the federal Health Insurance Portability
10 and Accountability Act (HIPAA).

11 (d) In all cases in which documents are inspected or copies of
12 those documents are received, their acquisition or review shall be
13 arranged so as not to unnecessarily disrupt the medical and business
14 operations of the licensee or of the facility where the records are
15 kept or used.

16 (e) If documents are lawfully requested from licensees in
17 accordance with this section by the Attorney General or his or her
18 agents or deputies, or investigators of the board or the California
19 Board of Podiatric Medicine, the documents shall be provided
20 within 15 business days of receipt of the request, unless the licensee
21 is unable to provide the documents within this time period for good
22 cause, including, but not limited to, physical inability to access
23 the records in the time allowed due to illness or travel. Failure to
24 produce requested documents or copies thereof, after being
25 informed of the required deadline, shall constitute unprofessional
26 conduct. The board may use its authority to cite and fine a
27 physician and surgeon for any violation of this section. This remedy
28 is in addition to any other authority of the board to sanction a
29 licensee for a delay in producing requested records.

30 (f) Searches conducted of the office or medical facility of any
31 licensee shall not interfere with the recordkeeping format or
32 preservation needs of any licensee necessary for the lawful care
33 of patients.

34 ~~SEC. 67.~~

35 *SEC. 66.* Section 2228.1 is added to the Business and
36 Professions Code, to read:

37 2228.1. (a) On and after July 1, 2018, except as otherwise
38 provided in subdivision (c), the board shall require a licensee to
39 provide a separate disclosure that includes the licensee's probation
40 status, the length of the probation and the probation end date, all

1 practice restrictions placed on the licensee by the board, the board's
2 telephone number, and an explanation of how the patient can find
3 further information on the licensee's probation on the licensee's
4 profile page on the board's online license information *Internet*
5 *Web* site, to a patient or the patient's guardian or health care
6 surrogate prior to the patient's first visit following the probationary
7 order while the licensee is on probation pursuant to a probationary
8 order made after July 1, 2018, in any of the following
9 circumstances:

10 (1) ~~The accusation alleges, the statement of issues indicates, or~~
11 ~~the legal conclusions of an administrative law judge find or in a~~
12 ~~stipulated settlement the licensee admits, or if no admissions, the~~
13 ~~accusation or the statement of issues charges,~~ that the licensee is
14 implicated in any of the following:

15 (A) Sexual misconduct.

16 (B) Drug or alcohol abuse during practice.

17 (C) Criminal conviction involving the practice of medicine.

18 (2) If the licensee has previously surrendered his or her license,
19 had his or her license revoked, or has been ordered to be on
20 ~~probation:~~ *probation for a violation constituting a threat to public*
21 *health and safety.*

22 (3) Any violation *constituting a threat to public health and*
23 *safety* where the board believes notification is appropriate.

24 (b) A licensee required to provide a disclosure pursuant to
25 subdivision (a) shall obtain from the patient, or the patient's
26 guardian or health care surrogate, a separate, signed copy of that
27 disclosure.

28 (c) A licensee shall not be required to provide a disclosure
29 pursuant to subdivision (a) if any of the following applies:

30 (1) The patient is unconscious or otherwise unable to
31 comprehend the disclosure and sign the copy of the disclosure
32 pursuant to subdivision (b) and a guardian or health care surrogate
33 is unavailable to comprehend the disclosure and sign the copy.

34 (2) The visit occurs in an emergency room or an urgent care
35 facility or the visit is ~~unscheduled:~~ *unscheduled, including*
36 *consultations in inpatient facilities.*

37 (3) The licensee who will be treating the patient during the visit
38 is not known to the patient until immediately prior to the start of
39 the visit.

1 (4) *The licensee does not have a direct treatment relationship*
2 *with the patient.*

3 (d) On and after July 1, 2018, the board shall provide the
4 following information, with respect to licensees on probation and
5 licensees practicing under probationary licenses, in plain view on
6 the licensee's profile page on the board's online license information
7 site.

8 (1) For probation imposed pursuant to a stipulated settlement,
9 the causes alleged in the operative accusation along with a
10 designation identifying those causes by which the licensee has
11 expressly admitted guilt and a statement that acceptance of the
12 settlement is not an admission of guilt.

13 (2) For probation imposed by an adjudicated decision of the
14 board, the causes for probation stated in the final probationary
15 order.

16 (3) For a licensee granted a probationary license, the causes by
17 which the probationary license was imposed.

18 (4) The length of the probation and end date.

19 (5) All practice restrictions placed on the license by the board.

20 (e) Section 2314 shall not apply to this section.

21 ~~SEC. 68.~~

22 ~~SEC. 67.~~ Section 2232 of the Business and Professions Code
23 is amended to read:

24 2232. (a) Except as provided in subdivisions (c), (d), and (e),
25 the board shall automatically revoke the license of any person who,
26 at any time after January 1, 1947, has been required to register as
27 a sex offender pursuant to the provisions of Section 290 of the
28 Penal Code, regardless of whether the related conviction has been
29 appealed. The board shall notify the licensee of the license
30 revocation and of his or her right to elect to have a hearing as
31 provided in subdivision (b).

32 (b) Upon revocation of the physician's and surgeon's certificate,
33 the holder of the certificate may request a hearing within 30 days
34 of the revocation. The proceeding shall be conducted in accordance
35 with the Administrative Procedure Act (Chapter 5 (commencing
36 with Section 11500) of Part 1 of Division 3 of Title 2 of the
37 Government Code).

38 (c) This section shall not apply to a person who is required to
39 register as a sex offender pursuant to Section 290 of the Penal

1 Code solely because of a misdemeanor conviction under Section
2 314 of the Penal Code.

3 (d) (1) Five years after the effective date of the revocation and
4 three years after successful discharge from parole, probation, or
5 both parole and probation if under simultaneous supervision, an
6 individual who after January 1, 1947, and prior to January 1, 2005,
7 was subject to subdivision (a), may petition the superior court, in
8 the county in which the individual has resided for, at minimum,
9 five years prior to filing the petition, to hold a hearing within one
10 year of the date of the petition, in order for the court to determine
11 whether the individual no longer poses a possible risk to patients.
12 The individual shall provide notice of the petition to the Attorney
13 General and to the board at the time of its filing. The Attorney
14 General and the board shall present written and oral argument to
15 the court on the merits of the petition.

16 (2) If the court finds that the individual no longer poses a
17 possible risk to patients, and there are no other underlying reasons
18 for which the board pursued disciplinary action, the court shall
19 order, in writing, the board to reinstate the individual's license
20 within 180 days of the date of the order. The board may issue a
21 probationary license to a person subject to this paragraph subject
22 to terms and conditions, including, but not limited to, any of the
23 conditions of probation specified in Section 2221.

24 (3) If the court finds that the individual continues to pose a
25 possible risk to patients, the court shall deny relief. The court's
26 decision shall be binding on the individual and the board, and the
27 individual shall be prohibited from filing a subsequent petition
28 under this section based on the same conviction.

29 (e) This section shall not apply to a person who has been relieved
30 under Section 290.5 of the Penal Code of his or her duty to register
31 as a sex offender, or whose duty to register has otherwise been
32 formally terminated under California law.

33 (f) If the related conviction of the certificate holder is overturned
34 on appeal, the revocation ordered pursuant to this section shall
35 automatically cease. Nothing in this subdivision shall prohibit the
36 board from pursuing disciplinary action based on any cause other
37 than the overturned conviction.

38 (g) The other provisions of this article setting forth a procedure
39 for the revocation of a physician's and surgeon's certificate shall
40 not apply to proceedings conducted pursuant to this section.

1 ~~SEC. 69.~~

2 *SEC. 68.* Section 2291.5 is added to the Business and
3 Professions Code, to read:

4 2291.5. A physician and surgeon's failure to comply with an
5 order issued under Section 820 ~~shall~~ *may* result in the issuance of
6 notification from the board to cease the practice of medicine within
7 three calendar days after being so notified. The physician and
8 surgeon shall cease the practice of medicine until the ordered
9 examinations have been completed. A physician and surgeon's
10 continued failure to comply with an order issued under Section
11 820 shall constitute grounds for the suspension or revocation of
12 his or her certificate.

13 ~~SEC. 70.~~

14 *SEC. 69.* Section 2334 of the Business and Professions Code
15 is amended to read:

16 2334. (a) Notwithstanding any other provision of law, with
17 respect to the use of expert testimony in matters brought by the
18 Medical Board of California, no expert testimony shall be permitted
19 by any party unless the following information is exchanged in
20 written form with counsel for the other party, as ordered by the
21 Office of Administrative Hearings:

22 (1) A curriculum vitae setting forth the qualifications of the
23 expert.

24 (2) A complete expert witness report, which must include the
25 following:

26 (A) A complete statement of all opinions the expert will express
27 and the bases and reasons for each opinion.

28 (B) The facts or data considered by the expert in forming the
29 opinions.

30 (C) Any exhibits that will be used to summarize or support the
31 opinions.

32 (3) A representation that the expert has agreed to testify at the
33 hearing.

34 (4) A statement of the expert's hourly and daily fee for providing
35 testimony and for consulting with the party who retained his or
36 her services.

37 (b) The exchange of the information described in subdivision
38 (a) shall be completed no later than 90 days from the filing of an
39 accusation or petition to revoke probation or 30 calendar days prior
40 to the originally scheduled commencement date of the hearing,

1 whichever occurs first, or as determined by an administrative law
2 judge when Section 11529 of the Government Code applies.

3 (c) The Office of Administrative Hearings may adopt regulations
4 governing the required exchange of the information described in
5 this section.

6 ~~SEC. 71.~~

7 *SEC. 70.* Section 2415 of the Business and Professions Code
8 is amended to read:

9 2415. (a) Any physician and surgeon or any doctor of podiatric
10 medicine, as the case may be, who as a sole proprietor, or in a
11 partnership, group, or professional corporation, desires to practice
12 under any name that would otherwise be a violation of Section
13 2285 may practice under that name if the proprietor, partnership,
14 group, or corporation obtains and maintains in current status a
15 fictitious-name permit issued by the Division of Licensing, or, in
16 the case of doctors of podiatric medicine, the California Board of
17 Podiatric Medicine, under the provisions of this section.

18 (b) The division or the board shall issue a fictitious-name permit
19 authorizing the holder thereof to use the name specified in the
20 permit in connection with his, her, or its practice if the division or
21 the board finds to its satisfaction that:

22 (1) The applicant or applicants or shareholders of the
23 professional corporation hold valid and current licenses as
24 physicians and surgeons or doctors of podiatric medicine, as the
25 case may be.

26 (2) The professional practice of the applicant or applicants is
27 wholly owned and entirely controlled by the applicant or applicants.

28 (3) The name under which the applicant or applicants propose
29 to practice is not deceptive, misleading, or confusing.

30 (c) Each permit shall be accompanied by a notice that shall be
31 displayed in a location readily visible to patients and staff. The
32 notice shall be displayed at each place of business identified in the
33 permit.

34 (d) This section shall not apply to licensees who contract with,
35 are employed by, or are on the staff of, any clinic licensed by the
36 State Department of Health Care Services under Chapter 1
37 (commencing with Section 1200) of Division 2 of the Health and
38 Safety Code or any medical school approved by the division or a
39 faculty practice plan connected with that medical school.

1 (e) Fictitious-name permits issued under this section shall be
2 subject to Article 19 (commencing with Section 2421) pertaining
3 to renewal of licenses.

4 (f) The division or the board may revoke or suspend any permit
5 issued if it finds that the holder or holders of the permit are not in
6 compliance with the provisions of this section or any regulations
7 adopted pursuant to this section. A proceeding to revoke or suspend
8 a fictitious-name permit shall be conducted in accordance with
9 Section 2230.

10 (g) A fictitious-name permit issued to any licensee in a sole
11 practice is automatically revoked in the event the licensee's
12 certificate to practice medicine or podiatric medicine is revoked.

13 (h) The division or the board may delegate to the executive
14 director, or to another official of the board, its authority to review
15 and approve applications for fictitious-name permits and to issue
16 those permits.

17 (i) The California Board of Podiatric Medicine shall administer
18 and enforce this section as to doctors of podiatric medicine and
19 shall adopt and administer regulations specifying appropriate
20 podiatric medical name designations.

21 ~~SEC. 72.~~

22 ~~SEC. 71.~~ Section 2420 of the Business and Professions Code
23 is repealed.

24 ~~SEC. 73.~~

25 ~~SEC. 72.~~ Section 2421 of the Business and Professions Code
26 is amended to read:

27 2421. As used in this article, the terms:

28 (a) "License" includes "certificate," "permit," and "registration."

29 (b) "Licensee" includes the holder of a license.

30 (c) "Licensing authority" means the board, which has
31 jurisdiction over a particular licensee.

32 ~~SEC. 74.~~

33 ~~SEC. 73.~~ Section 2422 of the Business and Professions Code
34 is repealed.

35 ~~SEC. 75.~~

36 ~~SEC. 74.~~ Section 2423 of the Business and Professions Code
37 is amended to read:

38 2423. (a) Notwithstanding Section 2422:

39 (1) All physician and surgeon's certificates, and certificates to
40 practice midwifery, research psychoanalyst registrations,

1 polysomnographic trainee, technician, and technologist
2 registrations, and fictitious-name permits shall expire at 12
3 midnight on the last day of the birth month of the licensee during
4 the second year of a two-year term if not renewed.

5 (2) Registrations of dispensing opticians will expire at midnight
6 on the last day of the month in which the license was issued during
7 the second year of a two-year term if not renewed.

8 (b) The board shall establish by regulation procedures for the
9 administration of a birth date renewal program, including, but not
10 limited to, the establishment of a system of staggered license
11 expiration dates such that a relatively equal number of licenses
12 expire monthly.

13 (c) To renew an unexpired license, the licensee shall, on or
14 before the dates on which it would otherwise expire, apply for
15 renewal on a form prescribed by the licensing authority and pay
16 the prescribed renewal fee.

17 ~~SEC. 76.~~

18 *SEC. 75.* Section 2435 of the Business and Professions Code
19 is amended to read:

20 2435. The following fees apply to the licensure of physicians
21 and surgeons:

22 (a) Each applicant for a certificate based upon a national board
23 diplomate certificate, each applicant for a certificate based on
24 reciprocity, and each applicant for a certificate based upon written
25 examination, shall pay a nonrefundable application and processing
26 fee, as set forth in subdivision (b), at the time the application is
27 filed.

28 (b) The application and processing fee shall be fixed by the
29 board by May 1 of each year, to become effective on July 1 of that
30 year. The fee shall be fixed at an amount necessary to recover the
31 actual costs of the licensing program as projected for the fiscal
32 year commencing on the date the fees become effective.

33 (c) Each applicant who qualifies for a certificate, as a condition
34 precedent to its issuance, in addition to other fees required herein,
35 shall pay an initial license fee, if any, in an amount fixed by the
36 board consistent with this section. The initial license fee shall not
37 exceed seven hundred ninety dollars (\$790). An applicant enrolled
38 in an approved postgraduate training program shall be required to
39 pay only 50 percent of the initial license fee.

1 (d) The biennial renewal fee shall be fixed by the board
2 consistent with this section and shall not exceed seven hundred
3 ninety dollars (\$790).

4 (e) Notwithstanding Section 163.5, the delinquency fee shall
5 be 10 percent of the biennial renewal fee.

6 (f) The duplicate certificate and endorsement fees shall each be
7 fifty dollars (\$50), and the certification and letter of good standing
8 fees shall each be ten dollars (\$10).

9 (g) It is the intent of the Legislature that, in setting fees pursuant
10 to this section, the board shall seek to maintain a reserve in the
11 Contingent Fund of the Medical Board of California in an amount
12 not less than two nor more than four months' operating
13 expenditures.

14 (h) Not later than January 1, 2012, the Office of State Audits
15 and Evaluations within the Department of Finance shall commence
16 a preliminary review of the board's financial status, including, but
17 not limited to, its projections related to expenses, revenues, and
18 reserves, and the impact of the loan from the Contingent Fund of
19 the Medical Board of California to the General Fund made pursuant
20 to the Budget Act of 2008. The office shall make the results of this
21 review available upon request by June 1, 2012. This review shall
22 be funded from the existing resources of the office during the
23 2011–12 fiscal year.

24 ~~SEC. 77.~~

25 *SEC. 76.* Section 2435.2 of the Business and Professions Code
26 is amended to read:

27 2435.2. (a) Notwithstanding any other provision of law, if
28 Article 14 (commencing with Section 2340) becomes inoperative
29 or the diversion program described in that article is discontinued,
30 the board shall reduce the amount of the following fees:

31 (1) The initial license fee, as described in subdivision (c) of
32 Section 2435.

33 (2) The biennial renewal fee, as described in subdivision (d) of
34 Section 2435.

35 (b) The amount of the reductions made pursuant to subdivision
36 (a) shall equal the board's cost of operating the diversion program.

37 (c) The board shall not make the reductions described in
38 subdivision (a) if a diversion program is established by statute and
39 requires the board to fund it in whole or in part from licensure
40 fees.

1 ~~SEC. 78.~~

2 ~~SEC. 77.~~ Section 2445 of the Business and Professions Code
3 is amended to read:

4 2445. All moneys paid to and received by the board shall be
5 paid into the State Treasury and shall be credited to the Contingent
6 Fund of the Medical Board of California. Those moneys shall be
7 reported at the beginning of each month, for the month preceding,
8 to the Controller.

9 Moneys in the contingent fund shall be available, upon
10 appropriation by the Legislature, for the use of the board and from
11 it shall be paid all salaries and all other expenses necessarily
12 incurred in carrying into effect the provisions of this chapter.

13 If there is any surplus in these receipts after the board's salaries
14 and expenses are paid, such surplus shall be applied solely to
15 expenses incurred under the provisions of this chapter. No surplus
16 in these receipts shall be deposited in or transferred to the General
17 Fund.

18 ~~SEC. 79.~~

19 ~~SEC. 78.~~ Section 2450 of the Business and Professions Code
20 is amended to read:

21 2450. There is a Board of Osteopathic Examiners of the State
22 of California, established by the Osteopathic Act, which shall be
23 known as the Osteopathic Medical Board of California which
24 enforces this chapter relating to persons holding or applying for
25 physician's and surgeon's certificates issued by the Osteopathic
26 Medical Board of California under the Osteopathic Act.

27 Persons who elect to practice using the term of suffix "M.D.,"
28 as provided in Section 2275, shall not be subject to this article,
29 and the Medical Board of California shall enforce the provisions
30 of this chapter relating to persons who made the election.

31 Notwithstanding any other law, the powers and duties of the
32 Osteopathic Medical Board of California, as set forth in this article
33 and under the Osteopathic Act, shall be subject to review by the
34 appropriate policy committees of the Legislature. The review shall
35 be performed as if this chapter were scheduled to be repealed as
36 of January 1, 2022.

37 ~~SEC. 80.~~

38 ~~SEC. 79.~~ Section 2454.5 of the Business and Professions Code
39 is amended to read:

1 2454.5. In order to ensure the continuing competence of
2 licensed osteopathic physicians and surgeons, the board shall adopt
3 and administer standards for the continuing education of those
4 licensees. The board shall require each licensed osteopathic
5 physician and surgeon to demonstrate satisfaction of the continuing
6 education requirements as a condition for the renewal of a license
7 at intervals of not less than one year nor more than two years.
8 Commencing January 1, 2018, the board shall require each licensed
9 osteopathic physician and surgeon to complete a minimum of 100
10 hours of American Osteopathic Association continuing education
11 hours during each two-year cycle, of which 40 hours shall be
12 completed in American Osteopathic Association Category 1
13 continuing education hours and the remaining 60 hours shall be
14 either American Osteopathic Association or American Medical
15 Association accredited as a condition for renewal of an active
16 license.

17 For purposes of this section, “American Osteopathic Association
18 Category 1” means continuing education activities and programs
19 approved for Category 1 credit by the Committee on Continuing
20 Medical Education of the American Osteopathic Association.

21 ~~SEC. 81.~~

22 ~~SEC. 80.~~ Section 2460 of the Business and Professions Code
23 is amended to read:

24 2460. (a) There is created in the Department of Consumer
25 Affairs the California Board of Podiatric Medicine.

26 (b) This section shall remain in effect only until January 1, 2021,
27 and as of that date is repealed. Notwithstanding any other law, the
28 repeal of this section renders the California Board of Podiatric
29 Medicine subject to review by the appropriate policy committees
30 of the Legislature.

31 (c) The amendments made by the act adding this subdivision
32 relating to podiatrists shall not be construed to change any rights
33 or privileges held by podiatrists prior to the enactment of the act.

34 ~~SEC. 82.~~

35 ~~SEC. 81.~~ Section 2461 of the Business and Professions Code
36 is amended to read:

37 2461. As used in this article:

38 (a) “Board” means the California Board of Podiatric Medicine.

(b) “Podiatric licensing authority” refers to any officer, board, commission, committee, or department of another state that may issue a license to practice podiatric medicine.

~~SEC. 83.~~

SEC. 82. Section 2472 of the Business and Professions Code is amended to read:

2472. (a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.

(b) As used in this chapter, “podiatric medicine” means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

(c) A doctor of podiatric medicine may not administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another licensed health care practitioner who is authorized to administer the required anesthetic within the scope of his or her practice.

(d) (1) A doctor of podiatric medicine may do the following:

(A) Perform surgical treatment of the ankle and tendons at the level of the ankle pursuant to subdivision (e).

(B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine.

(C) Perform a partial amputation of the foot no further proximal than the Chopart’s joint.

(2) Nothing in this subdivision shall be construed to permit a doctor of podiatric medicine to function as a primary surgeon for any procedure beyond his or her scope of practice.

(e) A doctor of podiatric medicine may perform surgical treatment of the ankle and tendons at the level of the ankle only in the following locations:

(1) A licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(2) A licensed surgical clinic, as defined in Section 1204 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on

1 the ankle, in a general acute care hospital described in paragraph
2 (1) and meets all the protocols of the surgical clinic.

3 (3) An ambulatory surgical center that is certified to participate
4 in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395
5 et seq.) of the federal Social Security Act, if the doctor of podiatric
6 medicine has surgical privileges, including the privilege to perform
7 surgery on the ankle, in a general acute care hospital described in
8 paragraph (1) and meets all the protocols of the surgical center.

9 (4) A freestanding physical plant housing outpatient services
10 of a licensed general acute care hospital, as defined in Section
11 1250 of the Health and Safety Code, if the doctor of podiatric
12 medicine has surgical privileges, including the privilege to perform
13 surgery on the ankle, in a general acute care hospital described in
14 paragraph (1). For purposes of this section, a “freestanding physical
15 plant” means any building that is not physically attached to a
16 building where inpatient services are provided.

17 (5) An outpatient setting accredited pursuant to subdivision (g)
18 of Section 1248.1 of the Health and Safety Code.

19 ~~SEC. 84.~~

20 *SEC. 83.* Section 2475 of the Business and Professions Code
21 is amended to read:

22 2475. Unless otherwise provided by law, no postgraduate
23 trainee, intern, resident postdoctoral fellow, or instructor may
24 engage in the practice of podiatric medicine, or receive
25 compensation therefor, or offer to engage in the practice of
26 podiatric medicine unless he or she holds a valid, unrevoked, and
27 unsuspended certificate to practice podiatric medicine issued by
28 the board. However, a graduate of an approved college or school
29 of podiatric medicine upon whom the degree doctor of podiatric
30 medicine has been conferred, who is issued a resident’s license,
31 which may be renewed annually for up to eight years for this
32 purpose by the board, and who is enrolled in a postgraduate training
33 program approved by the board, may engage in the practice of
34 podiatric medicine whenever and wherever required as a part of
35 that program and may receive compensation for that practice under
36 the following conditions:

37 (a) A graduate with a resident’s license in an approved
38 internship, residency, or fellowship program may participate in
39 training rotations outside the scope of podiatric medicine, under
40 the supervision of a physician and surgeon who holds a medical

1 doctor or doctor of osteopathy degree wherever and whenever
2 required as a part of the training program, and may receive
3 compensation for that practice. If the graduate fails to receive a
4 license to practice podiatric medicine under this chapter within
5 three years from the commencement of the postgraduate training,
6 all privileges and exemptions under this section shall automatically
7 cease.

8 (b) Hospitals functioning as a part of the teaching program of
9 an approved college or school of podiatric medicine in this state
10 may exchange instructors or resident or assistant resident doctors
11 of podiatric medicine with another approved college or school of
12 podiatric medicine not located in this state, or those hospitals may
13 appoint a graduate of an approved school as such a resident for
14 purposes of postgraduate training. Those instructors and residents
15 may practice and be compensated as provided in this section, but
16 that practice and compensation shall be for a period not to exceed
17 two years.

18 ~~SEC. 85.~~

19 *SEC. 84.* Section 2479 of the Business and Professions Code
20 is amended to read:

21 2479. The board shall issue a certificate to practice podiatric
22 medicine to each applicant who meets the requirements of this
23 chapter. Every applicant for a certificate to practice podiatric
24 medicine shall comply with the provisions of Article 4
25 (commencing with Section 2080) which are not specifically
26 applicable to applicants for a physician's and surgeon's certificate,
27 in addition to the provisions of this article.

28 ~~SEC. 86.~~

29 *SEC. 85.* Section 2486 of the Business and Professions Code
30 is amended to read:

31 2486. The board shall issue a certificate to practice podiatric
32 medicine if the applicant has submitted directly to the board from
33 the credentialing organizations verification that he or she meets
34 all of the following requirements:

35 (a) The applicant has graduated from an approved school or
36 college of podiatric medicine and meets the requirements of Section
37 2483.

38 (b) The applicant, within the past 10 years, has passed parts I,
39 II, and III of the examination administered by the National Board
40 of Podiatric Medical Examiners of the United States or has passed

1 a written examination that is recognized by the board to be the
2 equivalent in content to the examination administered by the
3 National Board of Podiatric Medical Examiners of the United
4 States.

5 (c) The applicant has satisfactorily completed the postgraduate
6 training required by Section 2484.

7 (d) The applicant has passed within the past 10 years any oral
8 and practical examination that may be required of all applicants
9 by the board to ascertain clinical competence.

10 (e) The applicant has committed no acts or crimes constituting
11 grounds for denial of a certificate under Division 1.5 (commencing
12 with Section 475).

13 (f) The board determines that no disciplinary action has been
14 taken against the applicant by any podiatric licensing authority
15 and that the applicant has not been the subject of adverse judgments
16 or settlements resulting from the practice of podiatric medicine
17 that the board determines constitutes evidence of a pattern of
18 negligence or incompetence.

19 (g) A disciplinary databank report regarding the applicant is
20 received by the board from the Federation of Podiatric Medical
21 Boards.

22 ~~SEC. 87.~~

23 *SEC. 86.* Section 2488 of the Business and Professions Code
24 is amended to read:

25 2488. The board shall issue a certificate to practice podiatric
26 medicine by credentialing if the applicant has submitted directly
27 to the board from the credentialing organizations verification that
28 he or she is licensed as a doctor of podiatric medicine in any other
29 state and meets all of the following requirements:

30 (a) The applicant has graduated from an approved school or
31 college of podiatric medicine.

32 (b) The applicant, within the past 10 years, has passed either
33 part III of the examination administered by the National Board of
34 Podiatric Medical Examiners of the United States or a written
35 examination that is recognized by the board to be the equivalent
36 in content to the examination administered by the National Board
37 of Podiatric Medical Examiners of the United States.

38 (c) The applicant has satisfactorily completed a postgraduate
39 training program approved by the Council on Podiatric Medical
40 Education.

1 (d) The applicant, within the past 10 years, has passed any oral
2 and practical examination that may be required of all applicants
3 by the board to ascertain clinical competence.

4 (e) The applicant has committed no acts or crimes constituting
5 grounds for denial of a certificate under Division 1.5 (commencing
6 with Section 475).

7 (f) The board determines that no disciplinary action has been
8 taken against the applicant by any podiatric licensing authority
9 and that the applicant has not been the subject of adverse judgments
10 or settlements resulting from the practice of podiatric medicine
11 that the board determines constitutes evidence of a pattern of
12 negligence or incompetence.

13 (g) A disciplinary databank report regarding the applicant is
14 received by the board from the Federation of Podiatric Medical
15 Boards.

16 ~~SEC. 88.~~

17 *SEC. 87.* Section 2492 of the Business and Professions Code
18 is amended to read:

19 2492. (a) The board shall examine every applicant for a
20 certificate to practice podiatric medicine to ensure a minimum of
21 entry-level competence at the time and place designated by the
22 board in its discretion, but at least twice a year.

23 (b) Unless the applicant meets the requirements of Section 2486,
24 applicants shall be required to have taken and passed the
25 examination administered by the National Board of Podiatric
26 Medical Examiners.

27 (c) The board may appoint qualified persons to give the whole
28 or any portion of any examination as provided in this article, who
29 shall be designated as examination commissioners. The board may
30 fix the compensation of those persons subject to the provisions of
31 applicable state laws and regulations.

32 (d) The provisions of Article 9 (commencing with Section 2170)
33 shall apply to examinations administered by the board except where
34 those provisions are in conflict with or inconsistent with the
35 provisions of this article.

36 ~~SEC. 89.~~

37 *SEC. 88.* Section 2499 of the Business and Professions Code
38 is amended to read:

39 2499. There is in the State Treasury the Board of Podiatric
40 Medicine Fund. Notwithstanding Section 2445, the board shall

1 report to the Controller at the beginning of each calendar month
2 for the month preceding the amount and source of all revenue
3 received by it on behalf of the board, pursuant to this chapter, and
4 shall pay the entire amount thereof to the Treasurer for deposit
5 into the fund. All revenue received by the board and the division
6 from fees authorized to be charged relating to the practice of
7 podiatric medicine shall be deposited in the fund as provided in
8 this section, and shall be available, upon appropriation of the
9 Legislature, to carry out the provisions of this chapter relating to
10 the regulation of the practice of podiatric medicine.

11 ~~SEC. 90.~~

12 *SEC. 89.* Section 2499.7 is added to the Business and
13 Professions Code, to read:

14 2499.7. (a) Certificates to practice podiatric medicine shall
15 expire at midnight on the last day of the birth month of the licensee
16 during the second year of a two-year term.

17 (b) To renew an unexpired certificate, the licensee, on or before
18 the date on which the certificate would otherwise expire, shall
19 apply for renewal on a form prescribed by the board and pay the
20 prescribed renewal fee.

21 ~~SEC. 91.~~

22 *SEC. 90.* Section 2525.2 of the Business and Professions Code
23 is amended to read:

24 2525.2. An individual who possesses a license in good standing
25 to practice medicine or osteopathy issued by the Medical Board
26 of California, the California Board of Podiatric Medicine, or the
27 Osteopathic Medical Board of California shall not recommend
28 medical cannabis to a patient, unless that person is the patient's
29 attending physician, as defined by subdivision (a) of Section
30 11362.7 of the Health and Safety Code.

31 ~~SEC. 92.~~

32 *SEC. 91.* The heading of Chapter 5.1 (commencing with Section
33 2529) of Division 2 of the Business and Professions Code is
34 repealed.

35 ~~SEC. 93.~~

36 *SEC. 92.* Section 2529 of the Business and Professions Code
37 is amended to read:

38 2529. (a) Graduates of the Southern California Psychoanalytic
39 Institute, the Los Angeles Psychoanalytic Society and Institute,
40 the San Francisco Psychoanalytic Institute, the San Diego

1 Psychoanalytic Center, or institutes deemed equivalent by the
2 Medical Board of California who have completed clinical training
3 in psychoanalysis may engage in psychoanalysis as an adjunct to
4 teaching, training, or research and hold themselves out to the public
5 as psychoanalysts, and students in those institutes may engage in
6 psychoanalysis under supervision, if the students and graduates
7 do not hold themselves out to the public by any title or description
8 of services incorporating the words “psychological,”
9 “psychologist,” “psychology,” “psychometrists,” “psychometrics,”
10 or “psychometry,” or that they do not state or imply that they are
11 licensed to practice psychology.

12 (b) Those students and graduates seeking to engage in
13 psychoanalysis under this chapter shall register with the Medical
14 Board of California, presenting evidence of their student or
15 graduate status. The board may suspend or revoke the exemption
16 of those persons for unprofessional conduct as defined in Sections
17 726, 2234, 2235, and 2529.1

18 (c) This section shall become inoperative on January 1, 2019,
19 and shall be repealed as of that date.

20 ~~SEC. 94.~~

21 *SEC. 93.* Section 2529.1 of the Business and Professions Code
22 is amended to read:

23 2529.1. (a) The use of any controlled substance or the use of
24 any of the dangerous drugs specified in Section 4022, or of
25 alcoholic beverages, to the extent, or in such a manner as to be
26 dangerous or injurious to the registrant, or to any other person or
27 to the public, or to the extent that this use impairs the ability of
28 the registrant to practice safely or more than one misdemeanor or
29 any felony conviction involving the use, consumption, or
30 self-administration of any of the substances referred to in this
31 section, or any combination thereof, constitutes unprofessional
32 conduct. The record of the conviction is conclusive evidence of
33 this unprofessional conduct.

34 (b) A plea or verdict of guilty or a conviction following a plea
35 of nolo contendere is deemed to be a conviction within the meaning
36 of this section. The board may order discipline of the registrant in
37 accordance with Section 2227 or may order the denial of the
38 registration when the time for appeal has elapsed or the judgment
39 of conviction has been affirmed on appeal or when an order
40 granting probation is made suspending imposition of sentence,

1 irrespective of a subsequent order under the provisions of Section
2 1203.4 of the Penal Code allowing this person to withdraw his or
3 her plea of guilty and to enter a plea of not guilty, or setting aside
4 the verdict of guilty, or dismissing the accusation, complaint,
5 information, or indictment.

6 (c) This section shall become inoperative on January 1, 2019,
7 and shall be repealed as of that date.

8 ~~SEC. 95.~~

9 *SEC. 94.* Section 2529.5 of the Business and Professions Code
10 is amended to read:

11 2529.5. (a) Each person to whom registration is granted under
12 the provisions of this chapter shall pay into the Contingent Fund
13 of the Medical Board of California a fee to be fixed by the Medical
14 Board of California at a sum not in excess of one hundred dollars
15 (\$100).

16 (b) The registration shall expire after two years. The registration
17 may be renewed biennially at a fee to be fixed by the board at a
18 sum not in excess of fifty dollars (\$50). Students seeking to renew
19 their registration shall present to the board evidence of their
20 continuing student status.

21 (c) The money in the Contingent Fund of the Medical Board of
22 California shall be used for the administration of this chapter.

23 (d) This section shall become inoperative on January 1, 2019,
24 and shall be repealed as of that date.

25 ~~SEC. 96.~~

26 *SEC. 95.* Section 2529.6 of the Business and Professions Code
27 is amended to read:

28 2529.6. (a) Except as provided in subdivisions (b) and (c), the
29 board shall revoke the registration of any person who has been
30 required to register as a sex offender pursuant to Section 290 of
31 the Penal Code for conduct that occurred on or after January 1,
32 2017.

33 (b) This section shall not apply to a person who is required to
34 register as a sex offender pursuant to Section 290 of the Penal
35 Code solely because of a misdemeanor conviction under Section
36 314 of the Penal Code.

37 (c) This section shall not apply to a person who has been relieved
38 under Section 290.5 of the Penal Code of his or her duty to register
39 as a sex offender, or whose duty to register has otherwise been
40 formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become inoperative on January 1, 2019, and shall be repealed as of that date.

~~SEC. 97.~~

SEC. 96. Section 2566.2 is added to the Business and Professions Code, to read:

2566.2. Every registration issued to a dispensing optician, contact lens dispenser, and spectacle lens dispenser shall expire 24 months after the initial date of issuance. To renew an unexpired registration, the registrant shall, before the time at which the license would otherwise expire, apply for renewal on a form prescribed by the board, and pay the renewal fee prescribed by this chapter.

~~SEC. 98.~~ The heading of Article 3.5 (commencing with Section 2950) is added to Chapter 6.6 of Division 2 of the Business and Professions Code, to read:

~~Article 3.5. Research Psychoanalysts~~

~~SEC. 99.~~ Section 2950 is added to the Business and Professions Code, to read:

2950. (a) ~~Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the board, who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words “psychological,” “psychologist,” “psychology,” “psychometrists,” “psychometrics,” or “psychometry,” or that they do not state or imply that they are licensed to practice psychology.~~

(b) ~~Those students and graduates seeking to engage in psychoanalysis under this article shall register with the board, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for~~

unprofessional conduct as defined in Sections 726, 2960, 2960.6, 2969, and 2996.

(e) This section shall become operative on January 1, 2019.

SEC. 100. Section 2951 is added to the Business and Professions Code, to read:

2951. (a) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability of the registrant to practice safely, or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Article 4 (commencing with Section 2960) or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code, allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

(e) This section shall become operative on January 1, 2019.

SEC. 101. Section 2952 is added to the Business and Professions Code, to read:

2952. (a) Each person to whom registration is granted under the provisions of this chapter shall pay into the Psychology Fund a fee to be fixed by the board at a sum not in excess of one hundred dollars (\$100).

(b) The registration shall expire after two years. The registration may be renewed biennially at a fee to be fixed by the board at a sum not in excess of fifty dollars (\$50). Students seeking to renew their registration shall present to the board evidence of their continuing student status.

1 ~~(e) The money in the Contingent Fund of the Medical Board of~~
2 ~~California shall be used for the administration of this chapter. Any~~
3 ~~moneys within the Contingent Fund of the Medical Board of~~
4 ~~California collected pursuant to Chapter 5.1 (commencing with~~
5 ~~Section 2529) as it read before the enactment of the statute that~~
6 ~~added this section, shall be deposited in the Psychology Fund.~~

7 ~~(d) The board may employ, subject to civil service regulations,~~
8 ~~whatever additional clerical assistance is necessary for the~~
9 ~~administration of this article.~~

10 ~~(e) This section shall become operative on January 1, 2019.~~

11 ~~SEC. 102. Section 2953 is added to the Business and~~
12 ~~Professions Code, to read:~~

13 ~~2953. (a) Except as provided in subdivisions (b) and (c), the~~
14 ~~board shall revoke the registration of any person who has been~~
15 ~~required to register as a sex offender pursuant to Section 290 of~~
16 ~~the Penal Code for conduct that occurred on or after January 1,~~
17 ~~2017.~~

18 ~~(b) This section shall not apply to a person who is required to~~
19 ~~register as a sex offender pursuant to Section 290 of the Penal~~
20 ~~Code solely because of a misdemeanor conviction under Section~~
21 ~~314 of the Penal Code.~~

22 ~~(c) This section shall not apply to a person who has been relieved~~
23 ~~under Section 290.5 of the Penal Code of his or her duty to register~~
24 ~~as a sex offender, or whose duty to register has otherwise been~~
25 ~~formally terminated under California law.~~

26 ~~(d) A proceeding to revoke a registration pursuant to this section~~
27 ~~shall be conducted in accordance with Chapter 5 (commencing~~
28 ~~with Section 11500) of Part 1 of Division 3 of Title 2 of the~~
29 ~~Government Code.~~

30 ~~(e) This section shall become operative on January 1, 2019.~~

31 ~~SEC. 103. Section 2954 is added to the Business and~~
32 ~~Professions Code, to read:~~

33 ~~2954. (a) All agreements entered into with, and orders and~~
34 ~~regulations issued by, the Medical Board of California shall~~
35 ~~continue in effect as if the agreements were entered into with, and~~
36 ~~the orders and regulations were issued by, the Board of Psychology,~~
37 ~~respectively.~~

38 ~~(b) This section shall become operative on January 1, 2019.~~

~~SEC. 104.~~

SEC. 97. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon a

1 properly labeled prescription drug prepackaged by a physician and
2 surgeon, a manufacturer as defined in this chapter, or a pharmacist.

3 (b) The Medical Board of California, the State Board of
4 Optometry, the Bureau of Naturopathic Medicine, the Dental Board
5 of California, the California Board of Podiatric Medicine, the
6 Osteopathic Medical Board of California, the Board of Registered
7 Nursing, the Veterinary Medical Board, and the Physician Assistant
8 Committee shall have authority with the California State Board of
9 Pharmacy to ensure compliance with this section, and those boards
10 are specifically charged with the enforcement of this chapter with
11 respect to their respective licensees.

12 (c) “Prescriber,” as used in this section, means a person, who
13 holds a physician’s and surgeon’s certificate, a license to practice
14 optometry, a license to practice naturopathic medicine, a license
15 to practice dentistry, a license to practice veterinary medicine, or
16 a certificate to practice podiatry, and who is duly registered by the
17 Medical Board of California, the Osteopathic Medical Board of
18 California, the State Board of Optometry, the Bureau of
19 Naturopathic Medicine, the Dental Board of California, the
20 Veterinary Medical Board, or the California Board of Podiatric
21 Medicine.

22 ~~SEC. 105.~~

23 *SEC. 98.* Section 4175 of the Business and Professions Code
24 is amended to read:

25 4175. (a) The California State Board of Pharmacy shall
26 promptly forward to the appropriate licensing entity, including the
27 Medical Board of California, the Veterinary Medical Board, the
28 Dental Board of California, the State Board of Optometry, the
29 California Board of Podiatric Medicine, the Osteopathic Medical
30 Board of California, the Board of Registered Nursing, the Bureau
31 of Naturopathic Medicine, or the Physician Assistant Committee,
32 all complaints received related to dangerous drugs or dangerous
33 devices dispensed by a prescriber, certified nurse-midwife, nurse
34 practitioner, naturopathic doctor, or physician assistant pursuant
35 to Section 4170.

36 (b) All complaints involving serious bodily injury due to
37 dangerous drugs or dangerous devices dispensed by prescribers,
38 certified nurse-midwives, nurse practitioners, naturopathic doctors,
39 or physician assistants pursuant to Section 4170 shall be handled
40 by the Medical Board of California, the Dental Board of California,

1 the State Board of Optometry, the California Board of Podiatric
2 Medicine, the Osteopathic Medical Board of California, the Bureau
3 of Naturopathic Medicine, the Board of Registered Nursing, the
4 Veterinary Medical Board, or the Physician Assistant Committee
5 as a case of greatest potential harm to a patient.

6 ~~SEC. 106.~~

7 *SEC. 99.* Section 43.7 of the Civil Code is amended to read:

8 43.7. (a) There shall be no monetary liability on the part of,
9 and no cause of action for damages shall arise against, any member
10 of a duly appointed mental health professional quality assurance
11 committee that is established in compliance with Section 14725
12 of the Welfare and Institutions Code, for any act or proceeding
13 undertaken or performed within the scope of the functions of the
14 committee which is formed to review and evaluate the adequacy,
15 appropriateness, or effectiveness of the care and treatment planned
16 for, or provided to, mental health patients in order to improve
17 quality of care by mental health professionals if the committee
18 member acts without malice, has made a reasonable effort to obtain
19 the facts of the matter as to which he or she acts, and acts in
20 reasonable belief that the action taken by him or her is warranted
21 by the facts known to him or her after the reasonable effort to
22 obtain facts.

23 (b) There shall be no monetary liability on the part of, and no
24 cause of action for damages shall arise against, any professional
25 society, any member of a duly appointed committee of a medical
26 specialty society, or any member of a duly appointed committee
27 of a state or local professional society, or duly appointed member
28 of a committee of a professional staff of a licensed hospital
29 (provided the professional staff operates pursuant to written bylaws
30 that have been approved by the governing board of the hospital),
31 for any act or proceeding undertaken or performed within the scope
32 of the functions of the committee which is formed to maintain the
33 professional standards of the society established by its bylaws, or
34 any member of any peer review committee whose purpose is to
35 review the quality of medical, dental, dietetic, chiropractic,
36 optometric, acupuncture, psychotherapy, midwifery, or veterinary
37 services rendered by physicians and surgeons, dentists, dental
38 hygienists, podiatrists, registered dietitians, chiropractors,
39 optometrists, acupuncturists, veterinarians, marriage and family
40 therapists, professional clinical counselors, licensed midwives, or

1 psychologists, which committee is composed chiefly of physicians
2 and surgeons, dentists, dental hygienists, podiatrists, registered
3 dietitians, chiropractors, optometrists, acupuncturists, veterinarians,
4 marriage and family therapists, professional clinical counselors,
5 licensed midwives or psychologists for any act or proceeding
6 undertaken or performed in reviewing the quality of medical,
7 dental, dietetic, chiropractic, optometric, acupuncture,
8 psychotherapy, midwifery, or veterinary services rendered by
9 physicians and surgeons, dentists, dental hygienists, podiatrists,
10 registered dietitians, chiropractors, optometrists, acupuncturists,
11 veterinarians, marriage and family therapists, professional clinical
12 counselors, midwifery, or psychologists or any member of the
13 governing board of a hospital in reviewing the quality of medical
14 services rendered by members of the staff if the professional
15 society, committee, or board member acts without malice, has
16 made a reasonable effort to obtain the facts of the matter as to
17 which he, she, or it acts, and acts in reasonable belief that the action
18 taken by him, her, or it is warranted by the facts known to him,
19 her, or it after the reasonable effort to obtain facts. “Professional
20 society” includes legal, medical, psychological, dental, dental
21 hygiene, dietetic, accounting, optometric, acupuncture, podiatric,
22 pharmaceutical, chiropractic, physical therapist, veterinary, licensed
23 marriage and family therapy, licensed clinical social work, licensed
24 professional clinical counselor, and engineering organizations
25 having as members at least 25 percent of the eligible persons or
26 licentiates in the geographic area served by the particular society.
27 However, if the society has fewer than 100 members, it shall have
28 as members at least a majority of the eligible persons or licentiates
29 in the geographic area served by the particular society.

30 “Medical specialty society” means an organization having as
31 members at least 25 percent of the eligible physicians and surgeons
32 within a given professionally recognized medical specialty in the
33 geographic area served by the particular society.

34 (c) This section does not affect the official immunity of an
35 officer or employee of a public corporation.

36 (d) There shall be no monetary liability on the part of, and no
37 cause of action for damages shall arise against, any physician and
38 surgeon, podiatrist, or chiropractor who is a member of an
39 underwriting committee of an interindemnity or reciprocal or
40 interinsurance exchange or mutual company for any act or

proceeding undertaken or performed in evaluating physicians and surgeons, podiatrists, or chiropractors for the writing of professional liability insurance, or any act or proceeding undertaken or performed in evaluating physicians and surgeons for the writing of an interindemnity, reciprocal, or interinsurance contract as specified in Section 1280.7 of the Insurance Code, if the evaluating physician and surgeon, podiatrist, or chiropractor acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after the reasonable effort to obtain the facts.

(e) This section shall not be construed to confer immunity from liability on any quality assurance committee established in compliance with Section 14725 of the Welfare and Institutions Code or hospital. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a quality assurance committee established in compliance with Section 14725 of the Welfare and Institutions Code or hospital, the cause of action shall exist as if the preceding provisions of this section had not been enacted.

~~SEC. 107.~~

SEC. 100. Section 43.8 of the Civil Code is amended to read:

43.8. (a) In addition to the privilege afforded by Section 47, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person on account of the communication of information in the possession of that person to any hospital, hospital medical staff, veterinary hospital staff, professional society, medical, dental, podiatric, psychology, marriage and family therapy, professional clinical counselor, midwifery, or veterinary school, professional licensing board or division, committee or panel of a licensing board, the Senior Assistant Attorney General of the Health Quality Enforcement Section appointed under Section 12529 of the Government Code, peer review committee, quality assurance committees established in compliance with Sections 4070 and 5624 of the Welfare and Institutions Code, or underwriting committee described in Section 43.7 when the communication is intended to aid in the evaluation of the qualifications, fitness, character, or insurability of a practitioner of the healing or veterinary arts.

(b) The immunities afforded by this section and by Section 43.7 shall not affect the availability of any absolute privilege that may be afforded by Section 47.

(c) Nothing in this section is intended in any way to affect the California Supreme Court's decision in *Hassan v. Mercy American River Hospital* (2003) 31 Cal.4th 709, holding that subdivision (a) provides a qualified privilege.

~~SEC. 108.~~

SEC. 101. Section 13401 of the Corporations Code is amended to read:

13401. As used in this part:

(a) "Professional services" means any type of professional services that may be lawfully rendered only pursuant to a license, certification, or registration authorized by the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act.

(b) "Professional corporation" means a corporation organized under the General Corporation Law or pursuant to subdivision (b) of Section 13406 that is engaged in rendering professional services in a single profession, except as otherwise authorized in Section 13401.5, pursuant to a certificate of registration issued by the governmental agency regulating the profession as herein provided and that in its practice or business designates itself as a professional or other corporation as may be required by statute. However, any professional corporation or foreign professional corporation rendering professional services by persons duly licensed by the Medical Board of California or any examining committee under the jurisdiction of the board, the California Board of Podiatric Medicine, the Osteopathic Medical Board of California, the Dental Board of California, the Dental Hygiene Committee of California, the California State Board of Pharmacy, the Veterinary Medical Board, the California Architects Board, the Court Reporters Board of California, the Board of Behavioral Sciences, the Speech-Language Pathology and Audiology Board, the Board of Registered Nursing, or the State Board of Optometry shall not be required to obtain a certificate of registration in order to render those professional services.

(c) "Foreign professional corporation" means a corporation organized under the laws of a state of the United States other than this state that is engaged in a profession of a type for which there is authorization in the Business and Professions Code for the

1 performance of professional services by a foreign professional
2 corporation.

3 (d) “Licensed person” means any natural person who is duly
4 licensed under the provisions of the Business and Professions
5 Code, the Chiropractic Act, or the Osteopathic Act to render the
6 same professional services as are or will be rendered by the
7 professional corporation or foreign professional corporation of
8 which he or she is, or intends to become, an officer, director,
9 shareholder, or employee.

10 (e) “Disqualified person” means a licensed person who for any
11 reason becomes legally disqualified (temporarily or permanently)
12 to render the professional services that the particular professional
13 corporation or foreign professional corporation of which he or she
14 is an officer, director, shareholder, or employee is or was rendering.

15 ~~SEC. 109.~~

16 *SEC. 102.* Section 13401.5 of the Corporations Code is
17 amended to read:

18 13401.5. Notwithstanding subdivision (d) of Section 13401
19 and any other provision of law, the following licensed persons
20 may be shareholders, officers, directors, or professional employees
21 of the professional corporations designated in this section so long
22 as the sum of all shares owned by those licensed persons does not
23 exceed 49 percent of the total number of shares of the professional
24 corporation so designated herein, and so long as the number of
25 those licensed persons owning shares in the professional
26 corporation so designated herein does not exceed the number of
27 persons licensed by the governmental agency regulating the
28 designated professional corporation. This section does not limit
29 employment by a professional corporation designated in this section
30 to only those licensed professionals listed under each subdivision.
31 Any person duly licensed under Division 2 (commencing with
32 Section 500) of the Business and Professions Code, the
33 Chiropractic Act, or the Osteopathic Act may be employed to
34 render professional services by a professional corporation
35 designated in this section.

36 (a) Medical corporation.

37 (1) Licensed doctors of podiatric medicine.

38 (2) Licensed psychologists.

39 (3) Registered nurses.

40 (4) Licensed optometrists.

- 1 (5) Licensed marriage and family therapists.
- 2 (6) Licensed clinical social workers.
- 3 (7) Licensed physician assistants.
- 4 (8) Licensed chiropractors.
- 5 (9) Licensed acupuncturists.
- 6 (10) Naturopathic doctors.
- 7 (11) Licensed professional clinical counselors.
- 8 (12) Licensed physical therapists.
- 9 (13) Licensed pharmacists.
- 10 (14) Licensed midwives.
- 11 (b) Podiatric medical corporation.
- 12 (1) Licensed physicians and surgeons.
- 13 (2) Licensed psychologists.
- 14 (3) Registered nurses.
- 15 (4) Licensed optometrists.
- 16 (5) Licensed chiropractors.
- 17 (6) Licensed acupuncturists.
- 18 (7) Naturopathic doctors.
- 19 (8) Licensed physical therapists.
- 20 (c) Psychological corporation.
- 21 (1) Licensed physicians and surgeons.
- 22 (2) Licensed doctors of podiatric medicine.
- 23 (3) Registered nurses.
- 24 (4) Licensed optometrists.
- 25 (5) Licensed marriage and family therapists.
- 26 (6) Licensed clinical social workers.
- 27 (7) Licensed chiropractors.
- 28 (8) Licensed acupuncturists.
- 29 (9) Naturopathic doctors.
- 30 (10) Licensed professional clinical counselors.
- 31 (11) Licensed midwives.
- 32 (d) Speech-language pathology corporation.
- 33 (1) Licensed audiologists.
- 34 (e) Audiology corporation.
- 35 (1) Licensed speech-language pathologists.
- 36 (f) Nursing corporation.
- 37 (1) Licensed physicians and surgeons.
- 38 (2) Licensed doctors of podiatric medicine.
- 39 (3) Licensed psychologists.
- 40 (4) Licensed optometrists.

- 1 (5) Licensed marriage and family therapists.
- 2 (6) Licensed clinical social workers.
- 3 (7) Licensed physician assistants.
- 4 (8) Licensed chiropractors.
- 5 (9) Licensed acupuncturists.
- 6 (10) Naturopathic doctors.
- 7 (11) Licensed professional clinical counselors.
- 8 (12) Licensed midwives.
- 9 (g) Marriage and family therapist corporation.
- 10 (1) Licensed physicians and surgeons.
- 11 (2) Licensed psychologists.
- 12 (3) Licensed clinical social workers.
- 13 (4) Registered nurses.
- 14 (5) Licensed chiropractors.
- 15 (6) Licensed acupuncturists.
- 16 (7) Naturopathic doctors.
- 17 (8) Licensed professional clinical counselors.
- 18 (9) Licensed midwives.
- 19 (h) Licensed clinical social worker corporation.
- 20 (1) Licensed physicians and surgeons.
- 21 (2) Licensed psychologists.
- 22 (3) Licensed marriage and family therapists.
- 23 (4) Registered nurses.
- 24 (5) Licensed chiropractors.
- 25 (6) Licensed acupuncturists.
- 26 (7) Naturopathic doctors.
- 27 (8) Licensed professional clinical counselors.
- 28 (i) Physician assistants corporation.
- 29 (1) Licensed physicians and surgeons.
- 30 (2) Registered nurses.
- 31 (3) Licensed acupuncturists.
- 32 (4) Naturopathic doctors.
- 33 (5) Licensed midwives.
- 34 (j) Optometric corporation.
- 35 (1) Licensed physicians and surgeons.
- 36 (2) Licensed doctors of podiatric medicine.
- 37 (3) Licensed psychologists.
- 38 (4) Registered nurses.
- 39 (5) Licensed chiropractors.
- 40 (6) Licensed acupuncturists.

- 1 (7) Naturopathic doctors.
- 2 (k) Chiropractic corporation.
- 3 (1) Licensed physicians and surgeons.
- 4 (2) Licensed doctors of podiatric medicine.
- 5 (3) Licensed psychologists.
- 6 (4) Registered nurses.
- 7 (5) Licensed optometrists.
- 8 (6) Licensed marriage and family therapists.
- 9 (7) Licensed clinical social workers.
- 10 (8) Licensed acupuncturists.
- 11 (9) Naturopathic doctors.
- 12 (10) Licensed professional clinical counselors.
- 13 (11) Licensed midwives.
- 14 (l) Acupuncture corporation.
- 15 (1) Licensed physicians and surgeons.
- 16 (2) Licensed doctors of podiatric medicine.
- 17 (3) Licensed psychologists.
- 18 (4) Registered nurses.
- 19 (5) Licensed optometrists.
- 20 (6) Licensed marriage and family therapists.
- 21 (7) Licensed clinical social workers.
- 22 (8) Licensed physician assistants.
- 23 (9) Licensed chiropractors.
- 24 (10) Naturopathic doctors.
- 25 (11) Licensed professional clinical counselors.
- 26 (12) Licensed midwives.
- 27 (m) Naturopathic doctor corporation.
- 28 (1) Licensed physicians and surgeons.
- 29 (2) Licensed psychologists.
- 30 (3) Registered nurses.
- 31 (4) Licensed physician assistants.
- 32 (5) Licensed chiropractors.
- 33 (6) Licensed acupuncturists.
- 34 (7) Licensed physical therapists.
- 35 (8) Licensed doctors of podiatric medicine.
- 36 (9) Licensed marriage and family therapists.
- 37 (10) Licensed clinical social workers.
- 38 (11) Licensed optometrists.
- 39 (12) Licensed professional clinical counselors.
- 40 (13) Licensed midwives.

- 1 (n) Dental corporation.
- 2 (1) Licensed physicians and surgeons.
- 3 (2) Dental assistants.
- 4 (3) Registered dental assistants.
- 5 (4) Registered dental assistants in extended functions.
- 6 (5) Registered dental hygienists.
- 7 (6) Registered dental hygienists in extended functions.
- 8 (7) Registered dental hygienists in alternative practice.
- 9 (o) Professional clinical counselor corporation.
- 10 (1) Licensed physicians and surgeons.
- 11 (2) Licensed psychologists.
- 12 (3) Licensed clinical social workers.
- 13 (4) Licensed marriage and family therapists.
- 14 (5) Registered nurses.
- 15 (6) Licensed chiropractors.
- 16 (7) Licensed acupuncturists.
- 17 (8) Naturopathic doctors.
- 18 (9) Licensed midwives.
- 19 (p) Physical therapy corporation.
- 20 (1) Licensed physicians and surgeons.
- 21 (2) Licensed doctors of podiatric medicine.
- 22 (3) Licensed acupuncturists.
- 23 (4) Naturopathic doctors.
- 24 (5) Licensed occupational therapists.
- 25 (6) Licensed speech-language therapists.
- 26 (7) Licensed audiologists.
- 27 (8) Registered nurses.
- 28 (9) Licensed psychologists.
- 29 (10) Licensed physician assistants.
- 30 (11) Licensed midwives.
- 31 (q) Registered dental hygienist in alternative practice
- 32 corporation.
- 33 (1) Registered dental assistants.
- 34 (2) Licensed dentists.
- 35 (3) Registered dental hygienists.
- 36 (4) Registered dental hygienists in extended functions.
- 37 (r) Licensed midwifery corporation.
- 38 (1) Licensed physicians and surgeons.
- 39 (2) Licensed psychologists.
- 40 (3) Registered nurses.

- (4) Licensed marriage and family therapists.
- (5) Licensed clinical social workers.
- (6) Licensed physician assistants.
- (7) Licensed chiropractors.
- (8) Licensed acupuncturists.
- (9) Licensed naturopathic doctors.
- (10) Licensed professional clinical counselors.
- (11) Licensed physical therapists.

~~SEC. 110.~~

SEC. 103. Section 1157 of the Evidence Code is amended to read:

1157. (a) Neither the proceedings nor the records of organized committees of medical, medical-dental, podiatric, registered dietitian, psychological, marriage and family therapist, licensed clinical social worker, professional clinical counselor, pharmacist, or veterinary staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, or medical or dental review or dental hygienist review or chiropractic review or podiatric review or registered dietitian review or pharmacist review or veterinary review or acupuncturist review or licensed midwife review committees of local medical, dental, dental hygienist, podiatric, dietetic, pharmacist, veterinary, acupuncture, or chiropractic societies, marriage and family therapist, licensed clinical social worker, professional clinical counselor, or psychological review committees of state or local marriage and family therapist, state or local licensed clinical social worker, state or local licensed professional clinical counselor, or state or local psychological associations or societies or licensed midwife associations or societies having the responsibility of evaluation and improvement of the quality of care, shall be subject to discovery.

(b) Except as hereinafter provided, a person in attendance at a meeting of any of the committees described in subdivision (a) shall not be required to testify as to what transpired at that meeting.

(c) The prohibition relating to discovery or testimony does not apply to the statements made by a person in attendance at a meeting of any of the committees described in subdivision (a) if that person is a party to an action or proceeding the subject matter of which

1 was reviewed at that meeting, to a person requesting hospital staff
2 privileges, or in an action against an insurance carrier alleging bad
3 faith by the carrier in refusing to accept a settlement offer within
4 the policy limits.

5 (d) The prohibitions in this section do not apply to medical,
6 dental, dental hygienist, podiatric, dietetic, psychological, marriage
7 and family therapist, licensed clinical social worker, professional
8 clinical counselor, pharmacist, veterinary, acupuncture, midwifery,
9 or chiropractic society committees that exceed 10 percent of the
10 membership of the society, nor to any of those committees if a
11 person serves upon the committee when his or her own conduct
12 or practice is being reviewed.

13 (e) The amendments made to this section by Chapter 1081 of
14 the Statutes of 1983, or at the 1985 portion of the 1985–86 Regular
15 Session of the Legislature, at the 1990 portion of the 1989–90
16 Regular Session of the Legislature, at the 2000 portion of the
17 1999–2000 Regular Session of the Legislature, at the 2011 portion
18 of the 2011–12 Regular Session of the Legislature, or at the 2015
19 portion of the 2015–16 Regular Session of the Legislature, do not
20 exclude the discovery or use of relevant evidence in a criminal
21 action.

22 ~~SEC. 111.~~

23 *SEC. 104.* Section 11529 of the Government Code is amended
24 to read:

25 11529. (a) The administrative law judge of the Medical Quality
26 Hearing Panel established pursuant to Section 11371 may issue
27 an interim order suspending a license, imposing drug testing,
28 continuing education, supervision of procedures, limitations on
29 the authority to prescribe, furnish, administer, or dispense
30 controlled substances, or other license restrictions. Interim orders
31 may be issued only if the affidavits in support of the petition show
32 that the licensee has engaged in, or is about to engage in, acts or
33 omissions constituting a violation of the Medical Practice Act or
34 the appropriate practice act governing each allied health profession,
35 or is unable to practice safely due to a mental or physical condition,
36 and that permitting the licensee to continue to engage in the
37 profession for which the license was issued will endanger the
38 public health, safety, or welfare. The failure to comply with an
39 order issued pursuant to Section 820 of the Business and

1 Professions Code may constitute grounds to issue an interim
2 suspension order under this section.

3 (b) All orders authorized by this section shall be issued only
4 after a hearing conducted pursuant to subdivision (d), unless it
5 appears from the facts shown by affidavit that serious injury would
6 result to the public before the matter can be heard on notice. Except
7 as provided in subdivision (c), the licensee shall receive at least
8 15 days' prior notice of the hearing, which notice shall include
9 affidavits and all other information in support of the order.

10 (c) If an interim order is issued without notice, the administrative
11 law judge who issued the order without notice shall cause the
12 licensee to be notified of the order, including affidavits and all
13 other information in support of the order by a 24-hour delivery
14 service. That notice shall also include the date of the hearing on
15 the order, which shall be conducted in accordance with the
16 requirement of subdivision (d), not later than 20 days from the
17 date of issuance. The order shall be dissolved unless the
18 requirements of subdivision (a) are satisfied.

19 (d) For the purposes of the hearing conducted pursuant to this
20 section, the licentiate shall, at a minimum, have the following
21 rights:

22 (1) To be represented by counsel.

23 (2) To have a record made of the proceedings, copies of which
24 may be obtained by the licentiate upon payment of any reasonable
25 charges associated with the record.

26 (3) To present written evidence in the form of relevant
27 declarations, affidavits, and documents.

28 The discretion of the administrative law judge to permit
29 testimony at the hearing conducted pursuant to this section shall
30 be identical to the discretion of a superior court judge to permit
31 testimony at a hearing conducted pursuant to Section 527 of the
32 Code of Civil Procedure.

33 (4) To present oral argument.

34 (e) Consistent with the burden and standards of proof applicable
35 to a preliminary injunction entered under Section 527 of the Code
36 of Civil Procedure, the administrative law judge shall grant the
37 interim order if, in the exercise of discretion, the administrative
38 law judge concludes that:

39 (1) There is a reasonable probability that the petitioner will
40 prevail in the underlying action.

1 (2) The likelihood of injury to the public in not issuing the order
2 outweighs the likelihood of injury to the licensee in issuing the
3 order.

4 (f) In all cases in which an interim order is issued, and an
5 accusation or petition to revoke probation is not filed and served
6 pursuant to Sections 11503 and 11505 within 30 days of the date
7 on which the parties to the hearing on the interim order have
8 submitted the matter, the order shall be dissolved.

9 Upon service of the accusation or petition to revoke probation
10 the licensee shall have, in addition to the rights granted by this
11 section, all of the rights and privileges available as specified in
12 this chapter. If the licensee requests a hearing on the accusation,
13 the board shall provide the licensee with a hearing within 30 days
14 of the request, unless the licensee stipulates to a later hearing, and
15 a decision within 15 days of the date the decision is received from
16 the administrative law judge, or the board shall nullify the interim
17 order previously issued, unless good cause can be shown by the
18 Division of Medical Quality for a delay.

19 (g) If an interim order is issued, a written decision shall be
20 prepared within 15 days of the hearing, by the administrative law
21 judge, including findings of fact and a conclusion articulating the
22 connection between the evidence produced at the hearing and the
23 decision reached.

24 (h) Notwithstanding the fact that interim orders issued pursuant
25 to this section are not issued after a hearing as otherwise required
26 by this chapter, interim orders so issued shall be subject to judicial
27 review pursuant to Section 1094.5 of the Code of Civil Procedure.
28 The relief that may be ordered shall be limited to a stay of the
29 interim order. Interim orders issued pursuant to this section are
30 final interim orders and, if not dissolved pursuant to subdivision
31 (c) or (f), may only be challenged administratively at the hearing
32 on the accusation.

33 (i) The interim order provided for by this section shall be:

34 (1) In addition to, and not a limitation on, the authority to seek
35 injunctive relief provided for in the Business and Professions Code.

36 (2) A limitation on the emergency decision procedure provided
37 in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

38 ~~SEC. 112. Section 12529.6 of the Government Code is~~
39 ~~repealed.~~

1 *SEC. 105. Section 12529.6 of the Government Code is amended*
2 *to read:*

3 12529.6. (a) The Legislature finds and declares that the
4 Medical Board of California, by ensuring the quality and safety
5 of medical care, performs one of the most critical functions of state
6 government. Because of the critical importance of the board's
7 public health and safety function, the complexity of cases involving
8 alleged misconduct by physicians and surgeons, and the evidentiary
9 burden in the board's disciplinary cases, the Legislature finds and
10 declares that using a vertical enforcement and prosecution model
11 for those investigations is in the best interests of the people of
12 California.

13 ~~(b) Notwithstanding any other provision of law, as of January~~
14 ~~1, 2006, each complaint that is referred to a district office of the~~
15 ~~board for investigation shall be simultaneously and jointly assigned~~
16 ~~to an investigator and to the deputy attorney general in the Health~~
17 ~~Quality Enforcement Section responsible for prosecuting the case~~
18 ~~if the investigation results in the filing of an accusation. The joint~~
19 ~~assignment of the investigator and the deputy attorney general~~
20 ~~shall exist for the duration of the disciplinary matter. During the~~
21 ~~assignment, the investigator so assigned shall, under the direction~~
22 ~~but not the supervision of the deputy attorney general, be~~
23 ~~responsible for obtaining the evidence required to permit the~~
24 ~~Attorney General to advise the board on legal matters such as~~
25 ~~whether the board should file a formal accusation, dismiss the~~
26 ~~complaint for a lack of evidence required to meet the applicable~~
27 ~~burden of proof, or take other appropriate legal action.~~

28 ~~(c) The Medical Board of California, the Department of~~
29 ~~Consumer Affairs, and the Office of the Attorney General shall,~~
30 ~~if necessary, enter into an interagency agreement to implement~~
31 ~~this section.~~

32 ~~(d) This section does not affect the requirements of Section~~
33 ~~12529.5 as applied to the Medical Board of California where~~
34 ~~complaints that have not been assigned to a field office for~~
35 ~~investigation are concerned.~~

36 ~~(e) It is the intent of the Legislature to enhance the vertical~~
37 ~~enforcement and prosecution model as set forth in subdivision (a).~~
38 ~~The Medical Board of California shall do all of the following:~~

1 ~~(1) Increase its computer capabilities and compatibilities with~~
2 ~~the Health Quality Enforcement Section in order to share case~~
3 ~~information.~~

4 ~~(2) Establish and implement a plan to locate its enforcement~~
5 ~~staff and the staff of the Health Quality Enforcement Section in~~
6 ~~the same offices, as appropriate, in order to carry out the intent of~~
7 ~~the vertical enforcement and prosecution model.~~

8 ~~(3) Establish and implement a plan to assist in team building~~
9 ~~between its enforcement staff and the staff of the Health Quality~~
10 ~~Enforcement Section in order to ensure a common and consistent~~
11 ~~knowledge base.~~

12 *(b) It is the intent of the Legislature to establish a vertical*
13 *enforcement and prosecution model for the joint investigation of*
14 *an investigation conducted by the Health Quality Investigation*
15 *Unit established pursuant to Section 159.5 of the Business and*
16 *Professions Code and a deputy attorney general in the Health*
17 *Quality Enforcement Section.*

18 ~~SEC. 113.~~

19 *SEC. 106.* Section 11362.7 of the Health and Safety Code is
20 amended to read:

21 11362.7. For purposes of this article, the following definitions
22 shall apply:

23 (a) “Attending physician” means an individual who possesses
24 a license in good standing to practice medicine, podiatry, or
25 osteopathy issued by the Medical Board of California, the
26 California Board of Podiatric Medicine, or the Osteopathic Medical
27 Board of California and who has taken responsibility for an aspect
28 of the medical care, treatment, diagnosis, counseling, or referral
29 of a patient and who has conducted a medical examination of that
30 patient before recording in the patient’s medical record the
31 physician’s assessment of whether the patient has a serious medical
32 condition and whether the medical use of marijuana is appropriate.

33 (b) “Department” means the State Department of Public Health.

34 (c) “Person with an identification card” means an individual
35 who is a qualified patient who has applied for and received a valid
36 identification card pursuant to this article.

37 (d) “Primary caregiver” means the individual, designated by a
38 qualified patient or by a person with an identification card, who
39 has consistently assumed responsibility for the housing, health, or

1 safety of that patient or person, and may include any of the
2 following:

3 (1) In any case in which a qualified patient or person with an
4 identification card receives medical care or supportive services,
5 or both, from a clinic licensed pursuant to Chapter 1 (commencing
6 with Section 1200) of Division 2, a health care facility licensed
7 pursuant to Chapter 2 (commencing with Section 1250) of Division
8 2, a residential care facility for persons with chronic life-threatening
9 illness licensed pursuant to Chapter 3.01 (commencing with Section
10 1568.01) of Division 2, a residential care facility for the elderly
11 licensed pursuant to Chapter 3.2 (commencing with Section 1569)
12 of Division 2, a hospice, or a home health agency licensed pursuant
13 to Chapter 8 (commencing with Section 1725) of Division 2, the
14 owner or operator, or no more than three employees who are
15 designated by the owner or operator, of the clinic, facility, hospice,
16 or home health agency, if designated as a primary caregiver by
17 that qualified patient or person with an identification card.

18 (2) An individual who has been designated as a primary
19 caregiver by more than one qualified patient or person with an
20 identification card, if every qualified patient or person with an
21 identification card who has designated that individual as a primary
22 caregiver resides in the same city or county as the primary
23 caregiver.

24 (3) An individual who has been designated as a primary
25 caregiver by a qualified patient or person with an identification
26 card who resides in a city or county other than that of the primary
27 caregiver, if the individual has not been designated as a primary
28 caregiver by any other qualified patient or person with an
29 identification card.

30 (e) A primary caregiver shall be at least 18 years of age, unless
31 the primary caregiver is the parent of a minor child who is a
32 qualified patient or a person with an identification card or the
33 primary caregiver is a person otherwise entitled to make medical
34 decisions under state law pursuant to Sections 6922, 7002, 7050,
35 or 7120 of the Family Code.

36 (f) “Qualified patient” means a person who is entitled to the
37 protections of Section 11362.5, but who does not have an
38 identification card issued pursuant to this article.

39 (g) “Identification card” means a document issued by the State
40 Department of Public Health that identifies a person authorized to

1 engage in the medical use of marijuana and the person's designated
2 primary caregiver, if any.

3 (h) "Serious medical condition" means all of the following
4 medical conditions:

- 5 (1) Acquired immune deficiency syndrome (AIDS).
- 6 (2) Anorexia.
- 7 (3) Arthritis.
- 8 (4) Cachexia.
- 9 (5) Cancer.
- 10 (6) Chronic pain.
- 11 (7) Glaucoma.
- 12 (8) Migraine.
- 13 (9) Persistent muscle spasms, including, but not limited to,
14 spasms associated with multiple sclerosis.
- 15 (10) Seizures, including, but not limited to, seizures associated
16 with epilepsy.
- 17 (11) Severe nausea.
- 18 (12) Any other chronic or persistent medical symptom that
19 either:

20 (A) Substantially limits the ability of the person to conduct one
21 or more major life activities as defined in the Americans with
22 Disabilities Act of 1990 (Public Law 101-336).

23 (B) If not alleviated, may cause serious harm to the patient's
24 safety or physical or mental health.

25 (i) "Written documentation" means accurate reproductions of
26 those portions of a patient's medical records that have been created
27 by the attending physician, that contain the information required
28 by paragraph (2) of subdivision (a) of Section 11362.715, and that
29 the patient may submit to a county health department or the
30 county's designee as part of an application for an identification
31 card.

32 ~~SEC. 114.~~

33 *SEC. 107.* Section 128335 of the Health and Safety Code is
34 amended to read:

35 128335. (a) The office shall establish a nonprofit public benefit
36 corporation, to be known as the Health Professions Education
37 Foundation, that shall be governed by a board consisting of nine
38 members appointed by the Governor, one member appointed by
39 the Speaker of the Assembly, one member appointed by the Senate
40 Committee on Rules, and two members appointed by the Medical

1 Board of California. The members of the foundation board
2 appointed by the Governor, Speaker of the Assembly, and Senate
3 Committee on Rules may include representatives of minority
4 groups which are underrepresented in the health professions,
5 persons employed as health professionals, and other appropriate
6 members of health or related professions. All persons considered
7 for appointment shall have an interest in health programs, an
8 interest in health educational opportunities for underrepresented
9 groups, and the ability and desire to solicit funds for the purposes
10 of this article as determined by the appointing power. The
11 chairperson of the commission shall also be a nonvoting, ex officio
12 member of the board.

13 (b) The Governor shall appoint the president of the board of
14 trustees from among those members appointed by the Governor,
15 the Speaker of the Assembly, the Senate Committee on Rules, and
16 the Medical Board of California.

17 (c) The director, after consultation with the president of the
18 board, may appoint a council of advisers comprised of up to nine
19 members. The council shall advise the director and the board on
20 technical matters and programmatic issues related to the Health
21 Professions Education Foundation Program.

22 (d) Members of the board and members of the council shall
23 serve without compensation but shall be reimbursed for any actual
24 and necessary expenses incurred in connection with their duties
25 as members of the board or the council. The Medical Board of
26 California shall reimburse the members it appointed to the
27 foundation board for any actual and necessary expenses incurred
28 in connection with their duties as members of the foundation board.

29 (e) The foundation shall be subject to the Nonprofit Public
30 Benefit Corporation Law (Part 2 (commencing with Section 5110)
31 of Division 2 of Title 2 of the Corporations Code), except that if
32 there is a conflict with this article and the Nonprofit Public Benefit
33 Corporation Law (Part 2 (commencing with Section 5110) of
34 Division 2 of Title 2 of the Corporations Code), this article shall
35 prevail.

36 (f) This section shall become operative January 1, 2016.

37 ~~SEC. 115.~~

38 *SEC. 108.* No reimbursement is required by this act pursuant
39 to Section 6 of Article XIII B of the California Constitution because
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or
2 infraction, eliminates a crime or infraction, or changes the penalty
3 for a crime or infraction, within the meaning of Section 17556 of
4 the Government Code, or changes the definition of a crime within
5 the meaning of Section 6 of Article XIII B of the California
6 Constitution.

7 ~~SEC. 116.~~

8 *SEC. 109.* The repeal of the heading of Chapter 5.1
9 (commencing with Section 2529) of Division 2 of the Business
10 and Professions Code contained in Section ~~92~~ 91 of this act shall
11 not become operative until January 1, 2019.

MBC TRACKER II BILLS**7/19/2017**

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 12	Cooley	State Government: Administrative Regulations: Review	2-year Bill	
AB 64	Bonta	Cannabis: Licensure and Regulation	Sen. Approps	06/27/17
AB 77	Fong	Regulations: Effective Dates and Legislative Review	2-year Bill	02/07/17
AB 110	Ting	Cannabis: Medicinal and Adult Use	Sen. 3rd Reading	06/12/17
AB 154	Levine	Prisoners: Mental Health Treatment	Sen. 3rd Reading	07/13/17
AB 168	Eggman	Employers: Salary Information	Sen. Approps	06/06/17
AB 183	Lackey	Bill of Rights for State Excluded Employees	Asm. Inactive	05/25/17
AB 186	Eggman	Controlled Substances: Safer Drug Consumption Program	Sen. 3rd Reading	07/13/17
AB 207	Arambula	California State University: Doctor of Medicine Degrees	2-year Bill	02/22/17
AB 208	Eggman	Deferred Entry of Judgment: Pretrial Diversion	Sen. Approps	03/08/17
AB 224	Thurmond	Dentistry: Anesthesia and Sedation	Sen. B&P	05/30/17
AB 242	Arambula	Certificates of Death: Veterans	Sen. Approps	07/03/17
AB 244	Cervantes	Maternal Mental Health	2-year Bill	03/21/17
AB 247	Garcia, C.	Public Health: Childhood Lead Poisoning: Lead Advisory Taskforce	Sen. Approps	07/11/17
AB 251	Bonta	Health and Care Facilities: Dialysis Clinics	Sen. Approps	06/29/17
AB 259	Gipson	Medical Cannabis and Nonmedical Marijuana	Asm. Inactive	03/28/17
AB 265	Wood	Prescription Drugs: Prohibition on Price Discount	Sen. 3rd Reading	06/27/17
AB 340	Arambula	Early and Periodic Screening, Diagnosis, and Treatment Program	Sen. Approps	
AB 389	Salas	Marijuana: Consumer Guide	Sen. Approps	07/05/17
AB 395	Bocanegra	Substance Use Treatment Providers	Sen. 3rd Reading	07/06/17
AB 401	Aguilar-Curry	Pharmacy: Remote Dispensing Site Pharmacy: Telepharmacy	Sen. Approps	07/06/17
AB 422	Arambula	California State University: Doctor of Nursing Practice Degree	Sen. Approps	
AB 444	Ting	Medical Waste: Home Generated Medical Waste	Sen. Env. Quality	04/18/17
AB 447	Gray	Medi-Cal: Covered Benefits: Continuous Glucose Monitors	Sen. Approps	07/10/17
AB 451	Arambula	Health Facilities: Emergency Services and Care	Sen. Approps	07/05/17

MBC TRACKER II BILLS

7/19/2017

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 470	Arambula	Medi-Cal: Specialty Mental Health Services: Performance Dashboard	Sen. Approps	06/15/17
AB 508	Santiago	Health Care Practitioners: Student Loans	Sen. 3rd Reading	
AB 514	Salas	Medical Waste: Pharmaceuticals	Sen. Env. Quality	04/17/17
AB 547	Chavez	California Prompt Payment Act: Disabled Veteran Businesses	Sen. Approps	05/26/17
AB 613	Nazarian	Healing Arts: Clinical Laboratories	Sen. Approps	04/25/17
AB 632	Acosta	Small Business Procurement and Contract Act	2-year Bill	03/21/17
AB 635	Harper	Department of Consumer Affairs	2-year Bill	
AB 650	Dahle	Director of Technology: State Baseline Security Controls	2-year Bill	
AB 654	Maienschein	Pediatric Home Health Care	2-year Bill	03/13/17
AB 703	Flora	Professions and Vocations: Licenses: Fee Waivers	2-year Bill	
AB 710	Wood	Department of Consumer Affairs: Boards: Meetings	Sen. B&P	04/27/17
AB 720	Eggman	Inmates: Psychiatric Medication: Informed Consent	Sen. Approps	07/13/17
AB 728	Waldron	Health Care Coverage: Duchenne Muscular Dystrophy	2-year Bill	04/19/17
AB 750	Gallagher	Criminal Law: Competency: Department of State Hospitals	2-year Bill	03/30/17
AB 820	Gipson	Emergency Medical Services Authority: Task Force	2-year Bill	03/23/17
AB 826	Brough	Professions and Vocations	2-year Bill	
AB 827	Rubio	Department of Consumer Affairs: Task Force: Foreign-Trained Professionals	Sen. Approps	04/03/17
AB 835	Dababneh	Consumer Affairs: Licenses: Prohibited Acts	2-year Bill	03/27/17
AB 876	Acosta	State Agency Databases	2-year Bill	
AB 893	Garcia, E.	Public Health: Graduate Medical Education	Sen. Health	05/11/17
AB 937	Eggman	Health Care Decisions: Order of Priority	Sen. Health	05/03/17
AB 963	Gipson	Taxation: Marijuana	Asm. Inactive	05/30/17
AB 966	Chau	Public Health: Medication Assistance	2-year Bill	
AB 1003	Bloom	Healthy California Fund	2-year Bill	04/19/17
AB 1022	Irwin	Information Technology: Recovery Plans: Inventory	Sen. Approps	04/17/17

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1074	Maienschein	Health Care Coverage: Pervasive Developmental Disorder/Autism	Sen. Approps	06/20/17
AB 1098	McCarty	Child Death Investigations: Review Teams	Sen. Approps	05/26/17
AB 1153	Low	Podiatry	Sen. Approps	05/22/17
AB 1188	Nazarian	Health Professions Development: Loan Repayment	Sen. Approps	05/26/17
AB 1190	Obernolte	Department of Consumer Affairs: BreEZe System	Sen. Approps	06/13/17
AB 1315	Mullin	Mental Health: Early Psychosis Detection and Intervention	Sen. Approps	06/19/17
AB 1316	Quirk	Public Health: Childhood Lead Poisoning: Prevention	Sen. Approps	07/03/17
AB 1349	Daly	Diabetes: Strategy for Awareness and Prevention	2-year Bill	03/30/17
AB 1353	Waldron	Health Care Coverage: Prescription Drugs: Continuity of Care	2-year Bill	03/23/17
AB 1372	Levine	Crisis Stabilization Units: Psychiatric Patients	Sen. Approps	06/13/17
AB 1386	Waldron	Genomic Cancer Testing Program	Senate	05/26/17
AB 1466	Patterson	Patient Records	2-year Bill	
AB 1485	Rubio	California Health and Human Services Agency	2-year Bill	03/20/17
AB 1488	Thurmond	Health Care: Genetic Diseases	Sen. Health	05/30/17
AB 1539	Chen	Mental Health	2-year Bill	04/04/17
AB 1643	Bonta	Health Care for All Commission	2-year Bill	03/28/17
AB 1658	Frazier	State Agencies: Accountability	2-year Bill	03/21/17
AB 1685	Maienschein	Children's Mental Health	2-year Bill	
AB 1726	Comm. on Health	Vital Records: Confidentiality	Sen. 3rd Reading	07/06/17
AJR 19	Arambula	Opioid Awareness and Dependency Prevention	Assembly	
HR 6	Burke	Relative to Women's Reproductive Health	Adopted	
SB 17	Hernandez	Health Care: Prescription Drug Costs	Asm. Approps	07/05/17
SB 21	Hill	Law Enforcement Agencies: Surveillance: Policies	Asm. Approps	07/13/17
SB 22	Hill	Firearms: Law Enforcement Agencies: Accounting	2-year Bill	03/28/17
SB 23	Portantino	Public Health: Umbilical Cord Blood Collection	Sen. Approps	04/17/17

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 27	Morrell	Professions and Vocations: Licenses: Military Service	2-year Bill	04/17/17
SB 31	Lara	California Religious Freedom Act: State Agencies	Asm. Approps	03/27/17
SB 32	Moorlach	Public Employees Pension Reform Act of 2018	2-year Bill	03/02/17
SB 43	Hill	Antimicrobial-Resistant Infection: Reporting	Asm. Health	04/05/17
SB 76	Nielsen	Excluded Employees: Arbitration	Asm. Approps	06/29/17
SB 162	Allen	Marijuana and Medical Cannabis: Marketing	Asm. Approps	04/19/17
SB 172	Portantino	Health Care Coverage: Fertility Preservation	2-year Bill	05/01/17
SB 191	Beall	Pupil Health: Mental Health and Substance Use Disorder Svcs.	2-year Bill	03/28/17
SB 198	Galgiani	Hearing Aid Dispensers: Cerumen Management: Tympanometry	2-year Bill	04/17/17
SB 199	Hernandez	The California Health Care Cost, Quality, and Equity Atlas	Asm. Approps	03/30/17
SB 200	Morrell	Public Employees' Retirement Benefits: Final Compensation	2-year Bill	
SB 212	Jackson	Medical Waste	Asm. ES&TM	
SB 220	Pan	Medi-Cal Children's Health Advisory Panel	Asm. 3rd Reading	03/20/17
SB 221	Wiener	Health Care Coverage: Lipodystrophy Syndrome	2-year Bill	
SB 223	Atkins	Health Care Language Assistance Services	Asm. Approps	06/21/17
SB 227	Monning	Vocational Nurse: Feeding Tube Services	2-year Bill	
SB 244	Lara	Privacy: Agencies: Personal Information	Asm. Approps	07/13/17
SB 294	Hernandez	Hospices: Palliative Care	Assembly	05/26/17
SB 350	Galgiani	Incarcerated Persons: Health Records	2-year Bill	04/25/17
SB 374	Newman	Health Insurance: Discriminatory Practices: Mental Health	Enrollment	06/12/17
SB 392	Bates	Dentistry: Report: Access to Care: Pediatric Dental Patients	Asm. B&P	05/26/17
SB 399	Portantino	Health Care Coverage: Pervasive Developmental Disorder/Autism	2-year Bill	04/17/17
SB 432	Pan	Emergency Medical Services	Asm. Approps	07/12/17
SB 454	Moorlach	Public Employees' Health Benefits	2-year Bill	04/06/17
SB 456	Pan	Medi-Cal Managed Care: FQHCs and Rural Health Clinics	Asm. Approps	06/19/17

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 487	Pan	Practice of Medicine: Hospitals	2-year Bill	
SB 489	Bradford	Workers' Compensation: Change of Physician	Assembly	07/05/17
SB 501	Glazer	Dentistry: Anesthesia and Sedation: Report	Asm. Approps	05/01/17
SB 510	Stone	Pharmacies: Compounding	Asm. 3rd Reading	
SB 538	Monning	Hospital Contracts	Asm. Health	05/26/17
SB 555	Morrell	Regulations: 5-year Review and Report	2-year Bill	
SB 562	Lara	The Healthy California Act	Assembly	05/26/17
SB 572	Stone	Healing Arts Licensees: Violations: Grace Period	2-year Bill	03/27/17
SB 575	Leyva	Patient Access to Health Records	Asm. 3rd Reading	04/03/17
SB 648	Mendoza	Health and Care Facilities: Private Referral Agencies	2-year Bill	04/27/17
SB 657	Bates	California Public Records Act: Reverse Public Records Actions	2-year Bill	
SB 728	Newman	State Public Employees: Sick Leave: Veterans	Asm. Approps	07/06/17
SB 762	Hernandez	Healing Arts Licensee: License Activation Fee: Waiver	Asm. B&P	04/17/17
SB 783	Pan	State Employment: Unused Leave Buy-Back	2-year Bill	
SCA 8	Moorlach	Public Employee Retirement Benefits	Sen. PE&R	
SCA 10	Moorlach	Public Employee Retirement Benefits	Sen. PE&R	
SCR 18	Berryhill	Donate Life/DMV Partnership Month	Chaptered, #39	03/21/17
SCR 27	Gaines	Prostate Cancer Awareness Month	Assembly	
SR 12	Atkins	Relative to Women's Reproductive Health	Adopted	
SR 26	Hernandez	Relative to the Patient Protection and Affordable Care Act	Adopted	03/09/17